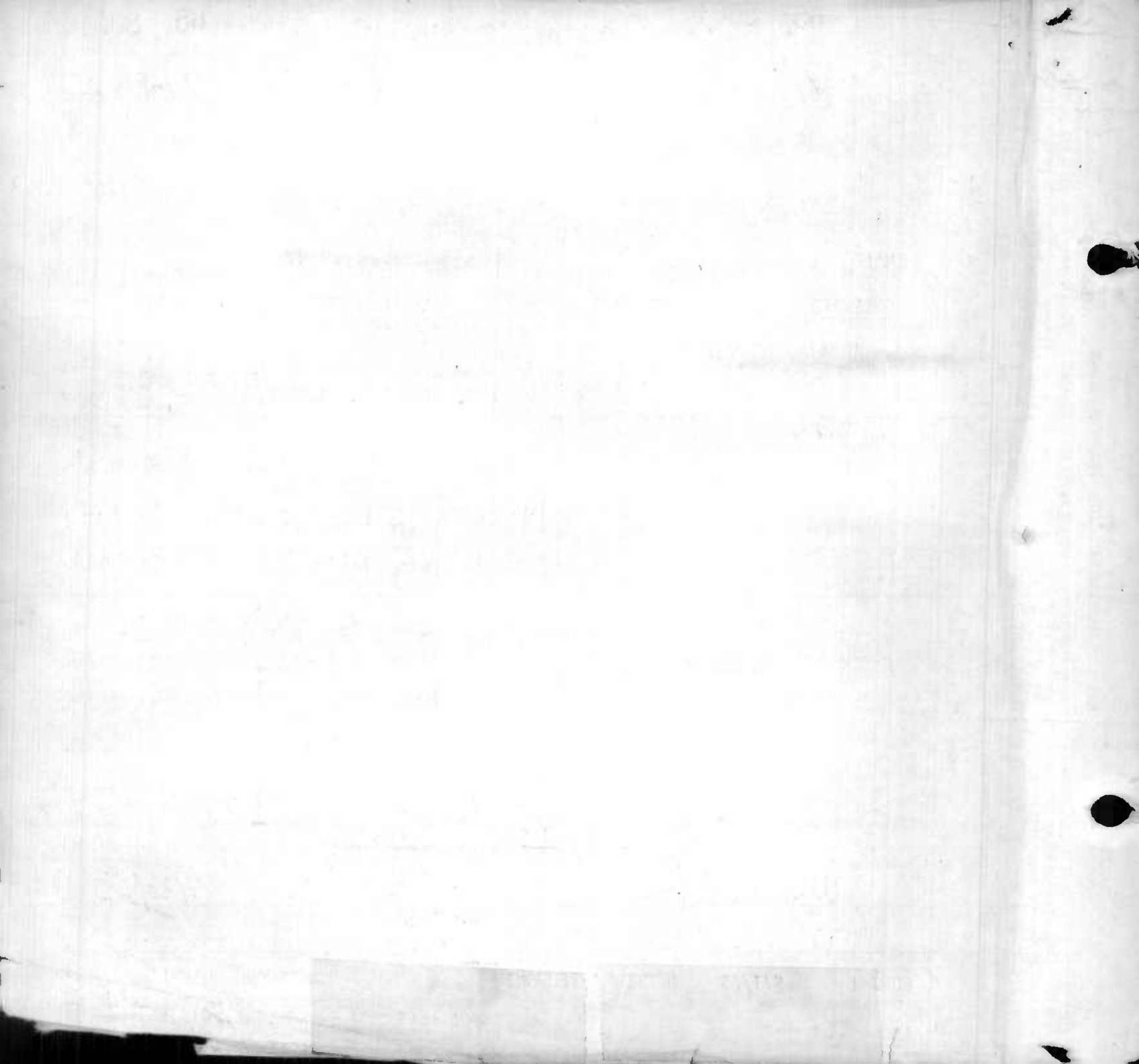


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68 70P
ARC BLANCHE

BIRTH NO. 65 8001		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8001	
M.E. CASE NO.			1. NAME OF DECEASED L. Blanche Goldberg		
2. DATE AND HOUR OF DEATH 7:25 AM 7/30/65			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore			5. SEX FEMALE		
6. RACE White			7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		
8. DATE OF BIRTH			9. AGE (In years lost birthday) 82		
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			11. BIRTHPLACE (State or foreign country) MASSACHUSETTS		
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME ABRAHAM SCHREIBER		
14. MOTHER'S MAIDEN NAME Anna			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.			17. INFORMANT MR. STUART B. GLOVER 530 5TH AVENUE NEW YORK, NEW YORK		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RESPIRATORY ARREST (A) DUE TO INTERTRACTABLE PULMONARY EDEMA (B) DUE TO MYOCARDIAL INFARCTION (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH 20 minutes 20 hours 30 hours		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. PANCYTOPENIA, ETIOLOGY UNKNOWN 24 years					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/28/65 to 7/30/65, that (I) (we) last saw the deceased alive on 7/30/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Allen D. Johnson				23B. DATE SIGNED 7/30/65	
23C. PHYSICIAN'S NAME (Type) Allen D. Johnson				23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/1/65		24C. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP	
24D. LOCATION BALTIMORE MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1965		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8002	
BIRTH NO. 65 8002		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SCHOTT TILLYE		2. DATE AND HOUR OF DEATH July 31st Aug 1 4:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD- B. COUNTY 21-20		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
		D. STREET ADDRESS (If rural, give location) 6101 Western Run Dr #9			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.Y.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JAMUEL MOSK		14. MOTHER'S MAIDEN NAME GERTRUDE MOSK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT EVELYN SCHWARTZ ADDRESS 6101 Western Run Dr. #9		
18. 45-4X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) CEREBRAL EMBOLISM DUE TO (B) GANGRENE OF Right Leg DUE TO acute multiple arterial occlusion		INTERVAL BETWEEN ONSET AND DEATH estimated about 6 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-25 19 65 to 8-1 19 65 , that (I) (we) lost saw the deceased alive on 8-1 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel D. Bass		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Aug 1, 1965	
23C. PHYSICIAN'S NAME (Type) DANIEL DAVID BASS		23D. ADDRESS M.D. SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 8/2/65	24C. NAME OF CEMETERY or CREMATORY HEBREW YOUNG MEN		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD	

FUNERAL DIRECTOR: IMPORTANT

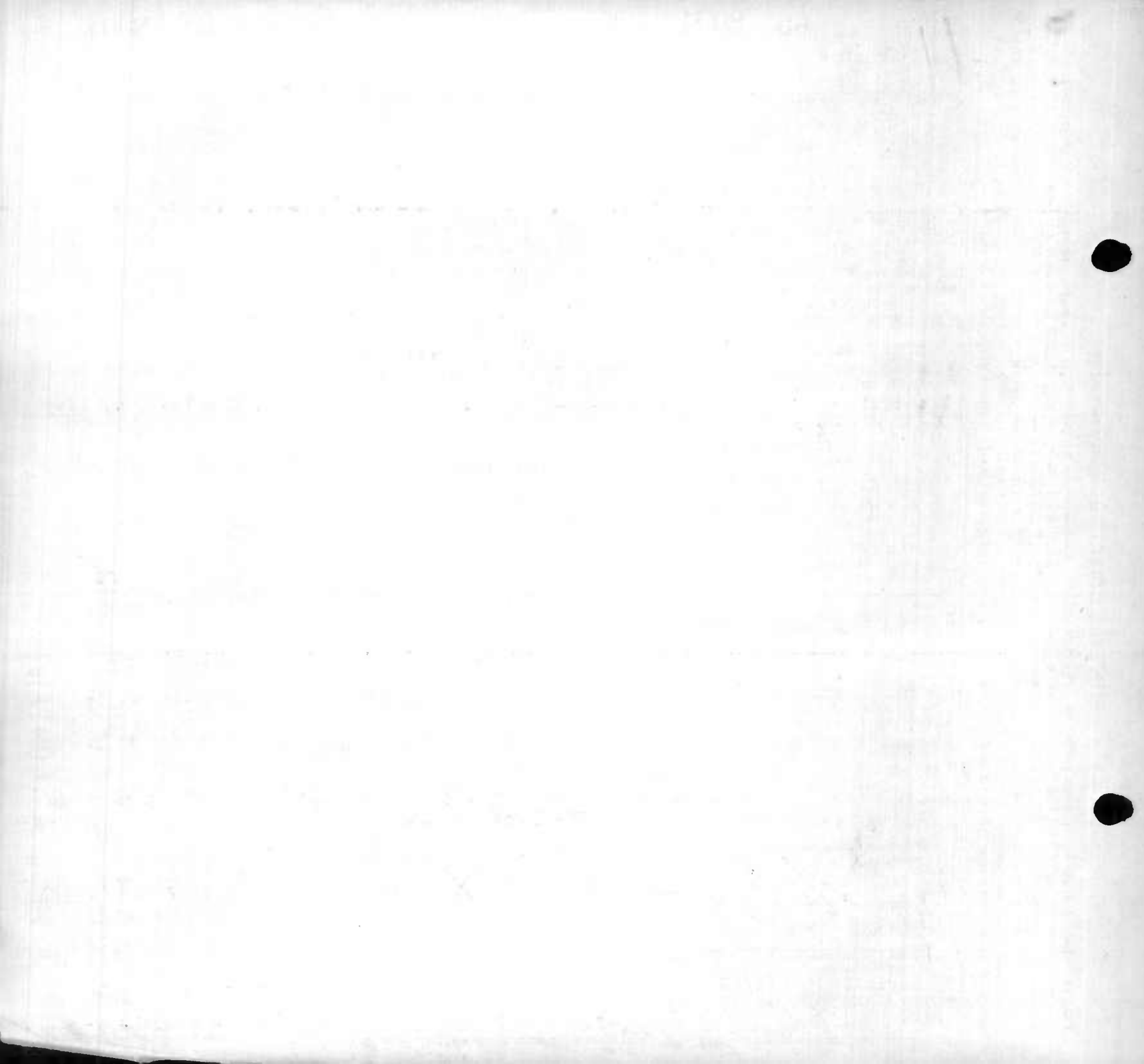
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8003		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8003	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) RANDALL C. SHAWVER		
2. DATE AND HOUR OF DEATH 7/31/65 1:00 P. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL			A. STATE MARYLAND B. COUNTY 27-48		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			D. STREET ADDRESS (If rural, give location) 914 WOODSON ROAD		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12/10/17	9. AGE (In years last birthday) 47	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10B. KIND OF BUSINESS OR INDUSTRY ROCK REAL ESTATE		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME RUTH SHAWVER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 219-12-8756		17. INFORMANT EVELYN J SHAWVER, 914 WOODSON RD, 21212	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) - ACUTE CORONARY THROMBOSIS, right DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) - MYOCARDIAL INFARCTION, POSTERIOR left VENTRICULAR WALL. DUE TO			
		(C) - CORONARY ARTERY SCLEROSIS, SEVERE			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Pants	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/1 1965 to 6/17 1965, that (I) (we) last saw the deceased alive on 7/31 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. R. Linton, Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/31/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-3-65		24C. NAME of CEMETERY or CREMATORY DULANEY VALLEY MEM.	
24D. LOCATION BALTIMORE COUNTY, MD.		25A. DATE REC'D BY HEALTH DEPT. AUG 3 1965		25B. NAME OF REGISTRAR Robert E. Fagund	
25C. FUNERAL DIRECTOR		25D. ADDRESS		25E. ADDRESS	
Ullrich Funeral Home		4210 Belair			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

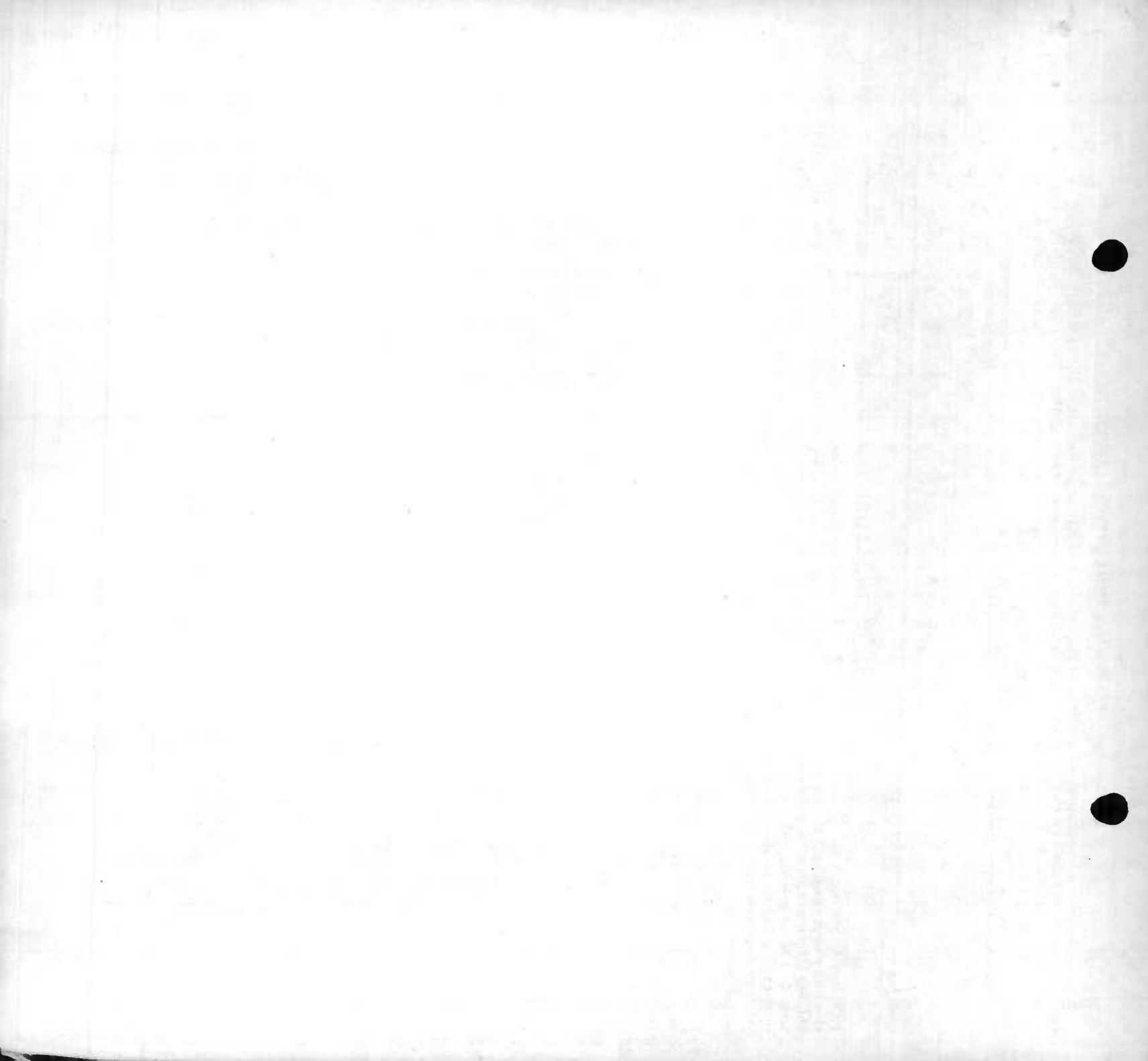
BIRTH NO. 65 8004		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 8004	
1. NAME OF DECEASED (Type or Print) LOUIE-DEE HONG			2. DATE AND HOUR OF DEATH JULY-30-1965		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION at his residence 2732-N-Calvert-St(21218)			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore City C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2732-N-Calvert-St. (21218)		
5. SEX Male	6. RACE Chinese	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) never married	8. DATE OF BIRTH ? ? 1898 ??	9. AGE (in years last birthday) ? abt 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant		10B. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (State or foreign country) Probably China		12. CITIZEN OF WHAT COUNTRY? ???????
13. FATHER'S NAME ???? Not available			14. MOTHER'S MAIDEN NAME ??? not available		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Doubtful		16. SOCIAL SECURITY NO. 213-38-6885	17. INFORMANT ADDRESS Mr. James Wu, 2430 N. Charles St., City		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) ARTERIO SCLEROTIC HEART DS. DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 4 years
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 7-6-1965 to 7-30-1965, that (I) (we) last saw the deceased alive on 7-20-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-31-65
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) burial	24B. DATE 8/2/65	24C. NAME OF CEMETERY or CREMATORY Lorraine Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Md. 21207	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Stewart & Mowen Co-108-N-North-Av-21201	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

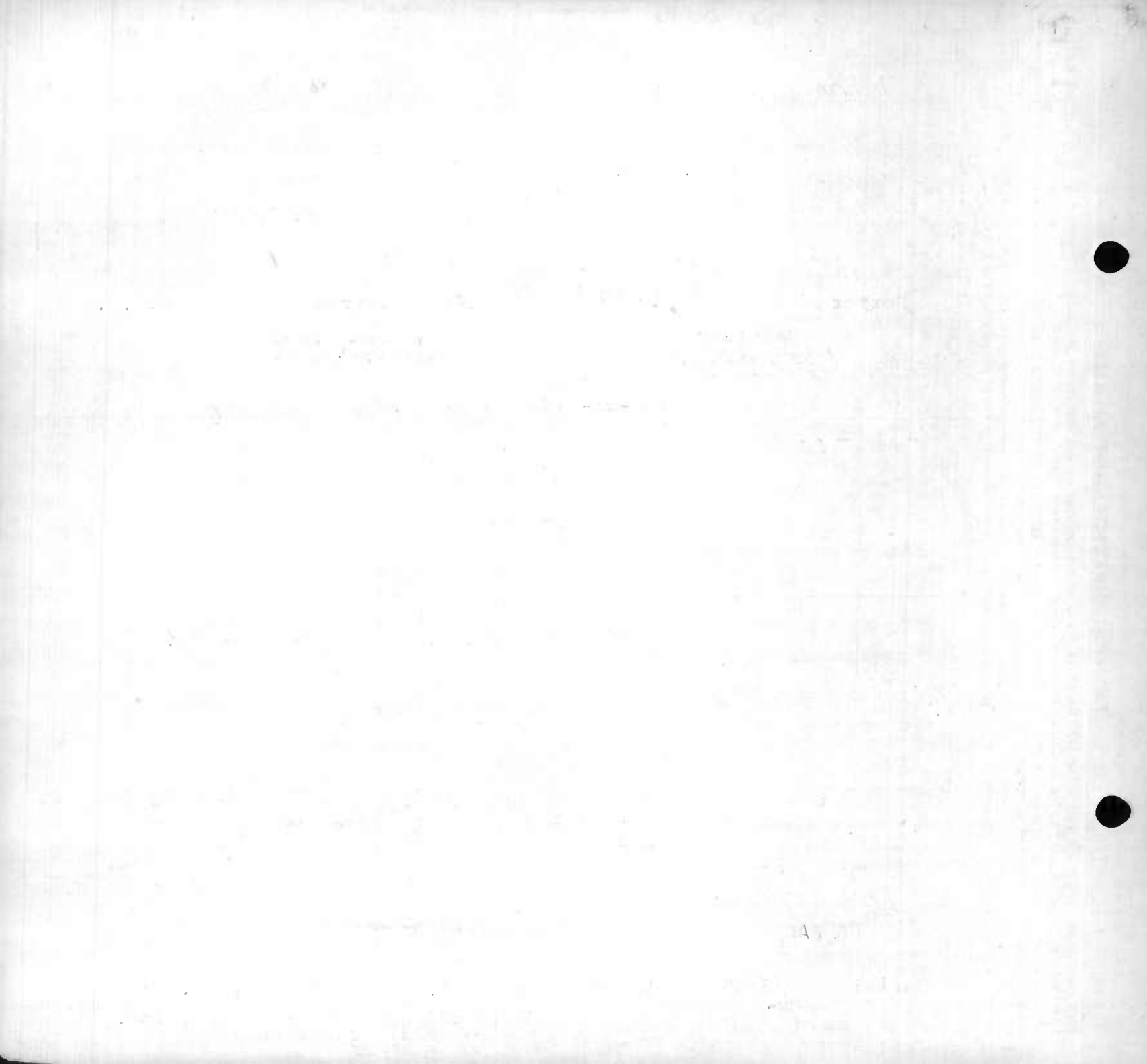
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8005	
BIRTH NO. 65 8005		CERTIFICATE OF DEATH		8.1.65 9:30 P.M.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Susie E DeWitt</i>		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>9-02</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland General Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		D. STREET ADDRESS (If rural, give location) <i>1516 Shady Side Rd.</i>	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>widow</i>	8. DATE OF BIRTH <i>8.14.86</i>	9. AGE (In years last birthday) <i>78</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Georgia</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Samuel Blackwell</i>		14. MOTHER'S MAIDEN NAME <i>Mary Waters</i>		17. INFORMANT <i>Hospital Chart</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>?</i>		ADDRESS	
18. <i>527.21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) DUE TO <i>Congestive Heart Failure</i> (B) DUE TO <i>Obstructive Airway Disease</i> (C)		INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs.</i> <i>40 yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7.31</i> 19 <i>65</i> to <i>8.1</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>8.1</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>R. Hinderstruth</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8.1.65</i>	
23C. PHYSICIAN'S NAME (Type) <i>R. Hinderstruth</i>		23D. ADDRESS M.D.			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>B</i>	24B. DATE <i>7-5-65</i>	24C. NAME of CEMETERY or CREMATORY <i>Cornth Babbisi</i>		24D. LOCATION (City, town, or county) (State) <i>Eggy RT, Ga</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 3 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>J. G. Catty</i>	
				ADDRESS <i>130 E. Fort Ave.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

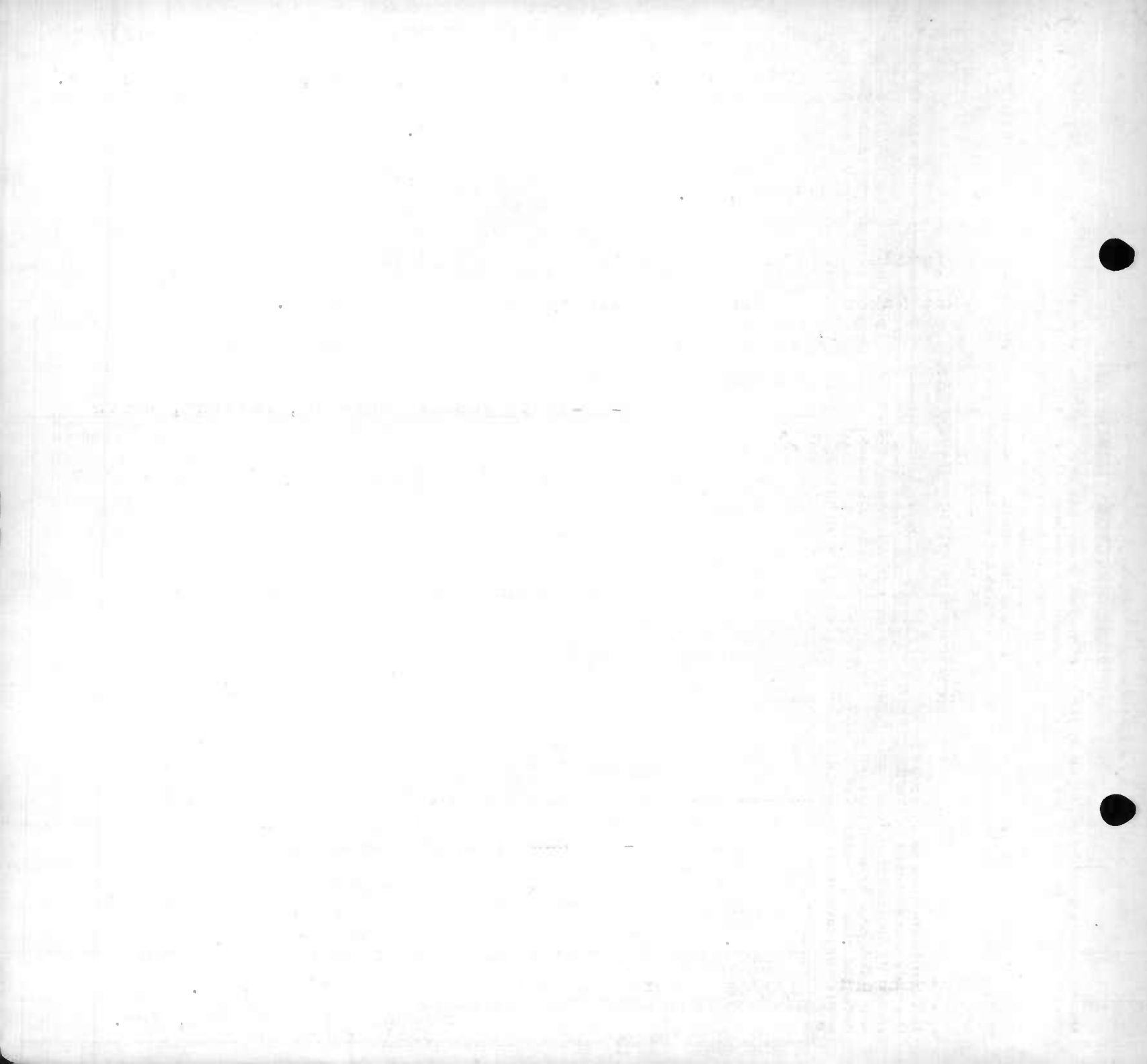
BIRTH NO. 65 8006		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8006	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <i>MARY KOFRON</i>		
2. DATE AND HOUR OF DEATH <i>8-2-65 7 A.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>41 Union Memorial Hosp Baltimore, Md. 21218</i>			A. STATE <i>Md.</i> B. COUNTY <i>7-01</i>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>		
			D. STREET ADDRESS (If rural, give location) <i>716 N. STREEPER</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>1-11-94</i>	9. AGE (In years lost birthday) <i>71</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sorter</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Gibbs Packing Co</i>	11. BIRTHPLACE (State or foreign country) <i>Austria</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Joseph Nahotsky</i>			14. MOTHER'S MAIDEN NAME <i>Frances Daeha</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO. <i>220-03-9148</i>		17. INFORMANT <i>Mrs Marie Berry</i> ADDRESS <i>(Daughter)</i>
18. <i>5-8-5-X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES			(A) <i>Heart failure</i> DUE TO		<i>3 days</i>
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <i>Acute Cholangitis</i> DUE TO		<i>3 days</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Hypertension & arteriosclerotic heart disease</i>					
19A. DATE OF OPERATION <i>1962</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cholecystectomy</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <i>July 30 1965</i> to <i>Aug 2 1965</i> , that (X) (we) last saw the deceased alive on <i>Aug 2 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Wayne Fann</i>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>Aug-2-1965</i>
23C. PHYSICIAN'S NAME (Type) <i>DR FAN</i>			23D. ADDRESS <i>Union Memorial Hospital Baltimore Md 21218</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/5/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 3 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fink</i>		25C. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i> ADDRESS <i>3331 Brehms Lane</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

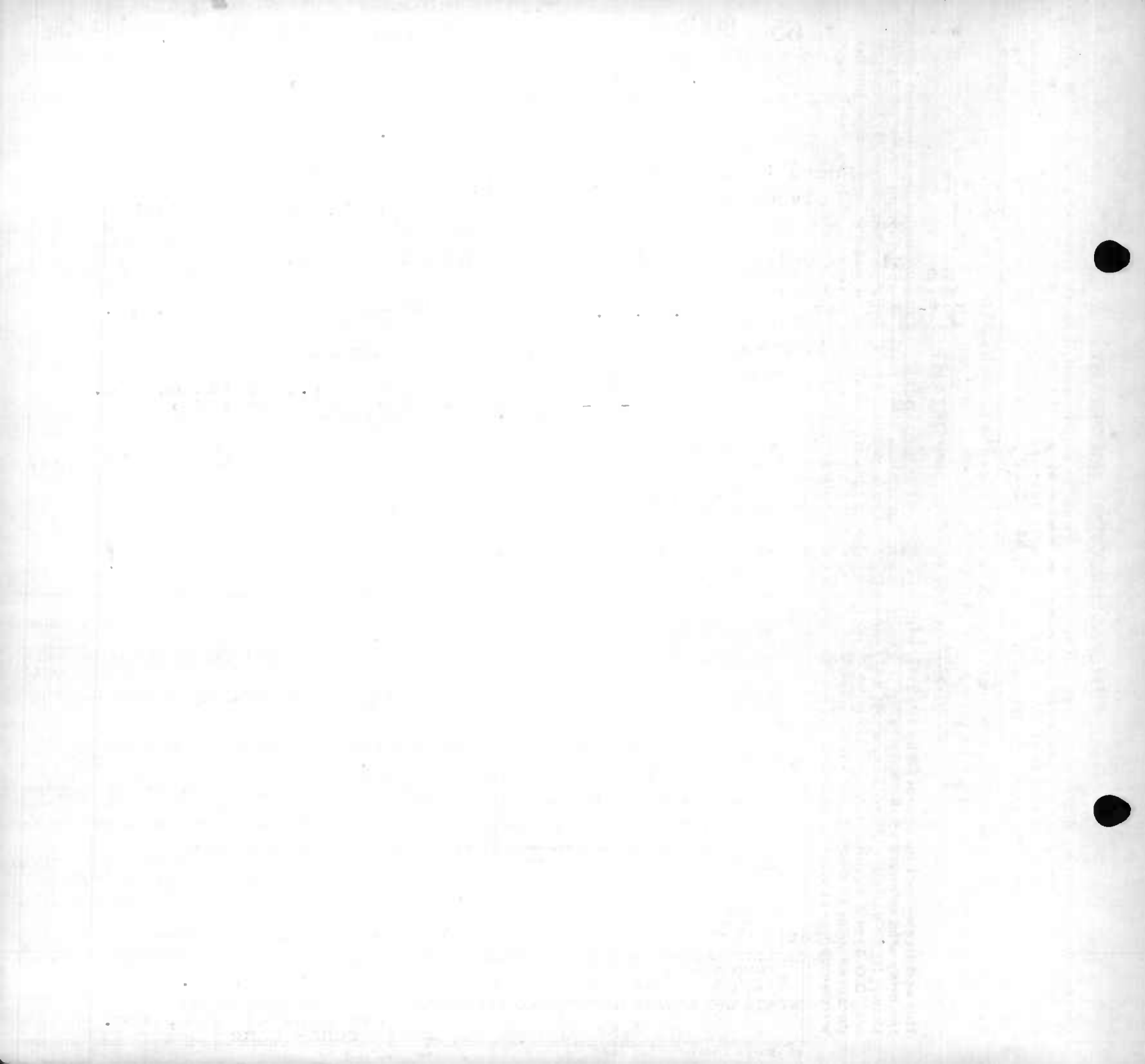
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8007	
BIRTH NO. 65 8007		CERTIFICATE OF DEATH			
M.E. CASE NO.		CATHERINE M. HANRATTY		2. DATE AND HOUR OF DEATH July 30, 1965 3:20 a. M.	
1. NAME OF DECEASED (Type or Print)					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3830 Kimble Road Baltimore, Md., 21218			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 7-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3830 Kimble Road		
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 8/20/1913	9. AGE (in years lost birthday) 51	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hat Maker		10B. KIND OF BUSINESS OR INDUSTRY Fashion Millinery Co		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME George Bys (Bish)			14. MOTHER'S MAIDEN NAME Agatha Szlachetha		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-10-8305	17. INFORMANT Thomas Hanratty, husband, above		
18. 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Carcinoma of uterus with generalized metastasis DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 15 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 1963		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of uterus		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 26, 1965 to July 30, 1965 , that (I) (we) last saw the deceased alive on July 29, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Lloyd E. Saylor</i> Dr. Lloyd E. Saylor				23B. DATE SIGNED July 31, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. Lloyd E. Saylor		23D. ADDRESS 3902 Greenmount Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment	24B. DATE 8/2/65	24C. NAME of CEMETERY or CREMATORY Lorraine Mausoleum		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1965		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8008		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8008	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		EDWARD S. BARRINGTON		July 29, 1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
House in the Pines (Belvedere)			Md. 7-01		
5. SEX			6. RACE		
male			white		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)			8. DATE OF BIRTH		
widowed			11/21/1887		
9. AGE (In years last birthday)			10. AGE (In years last birthday)		
77			77		
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
England			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Unknown			Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
no			717-07-8661		
17. INFORMANT			ADDRESS		
Major Paul Barrington, son,			6402 Boice St., Orelan, Fla.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO		
ANTECEDENT CAUSES			(B) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II			INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			8 to 10 mo		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from June 9 1965 to 7/29/65 that (I) (we) last saw the deceased alive on 7/29/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. Lester Kolman				7/30/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Lester Kolman				3700 Park Heights Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/2/65		Parkwood Cemetery	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 3 1965		Robert E. Farkner		Schimunek Funeral Home, Inc.	
				3331 Brehms Lane	

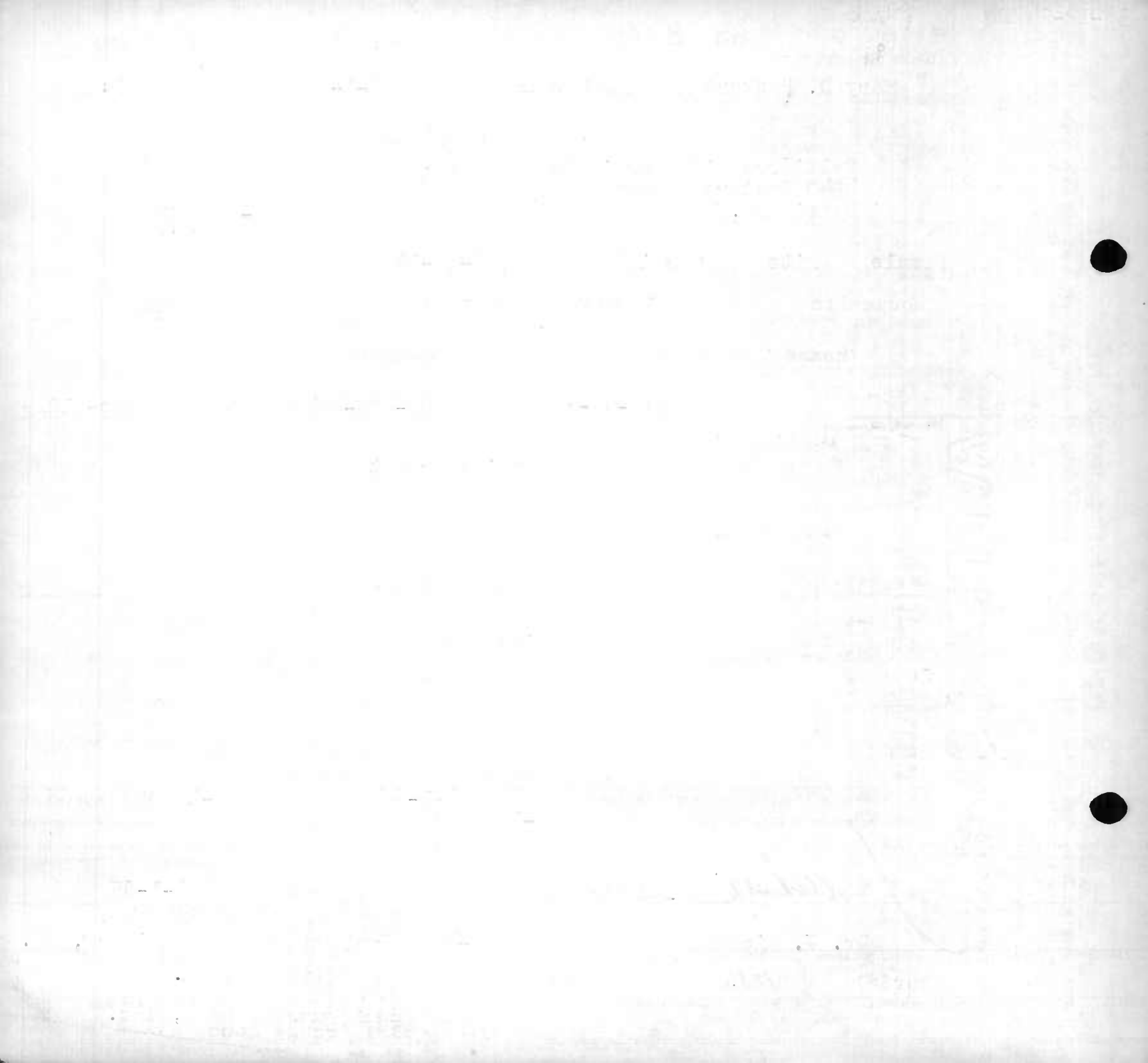


38-12-24 1B

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO.		8009				Registered No. 65 8009			
M.E. CASE NO. P-220		8009				8-1-65			
1. NAME OF DECEASED (Type or Print)		Mary D. Paskert or Paszkiewicz				2. DATE AND HOUR OF DEATH 8-1-65 11:15 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 457 A Burke Road - #21220			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5-20-03	9. AGE (In years last birthday) 62	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas Dobrostan		14. MOTHER'S MAIDEN NAME unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 213-09-2395		16. SOCIAL SECURITY NO. 213-09-2395		17. INFORMANT ADDRESS RECORDS-BCH-4940 Eastern Avenue-21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION CAUSING DEATH DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cardiac Arrest DUE TO (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Diabetes							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 8-1-65 19 to 8-1 1965, that (I) (we) last saw the deceased alive on 8-1 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Dr. J. Richmon		23B. DATE SIGNED 8-1-65		23C. PHYSICIAN'S NAME (Type) Dr. J. Richmon		23D. ADDRESS BCH-4940 Eastern Avenue-Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/5/65		24C. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1965		25B. NAME OF REGISTRAR Robert E. J. J.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 3331 Prehms Lane			



BIRTH NO.

65 8010

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 8010

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PERCY BRADLEY

2. DATE AND HOUR PRONOUNCED DEAD

July 28, 1965 11:50 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1540 N. Stricker St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

8/5/43

9. AGE (in years
last birthday)

21

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

MACHINE SHOP

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

PERCY

14. MOTHER'S MAIDEN NAME

ELIZABETH

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

MRS ELIZABETH WASHINGTON 1540 N Stricker St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cranio-cerebral injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1540 N. Stricker St.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
7 24 65 4:15p

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Apparently fell

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breiteneker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-29-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/2/65

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

AUG 3 1965

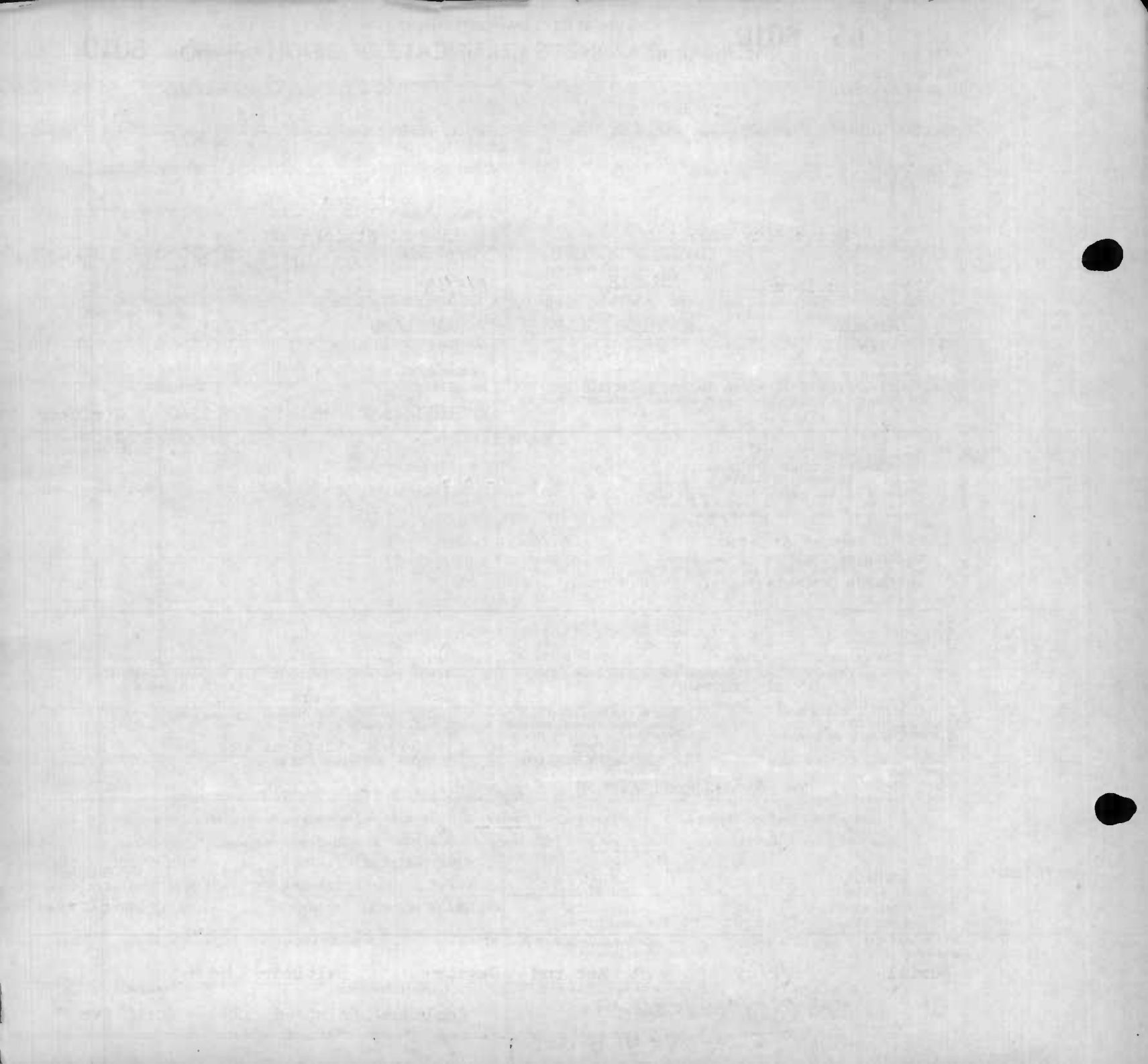
24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

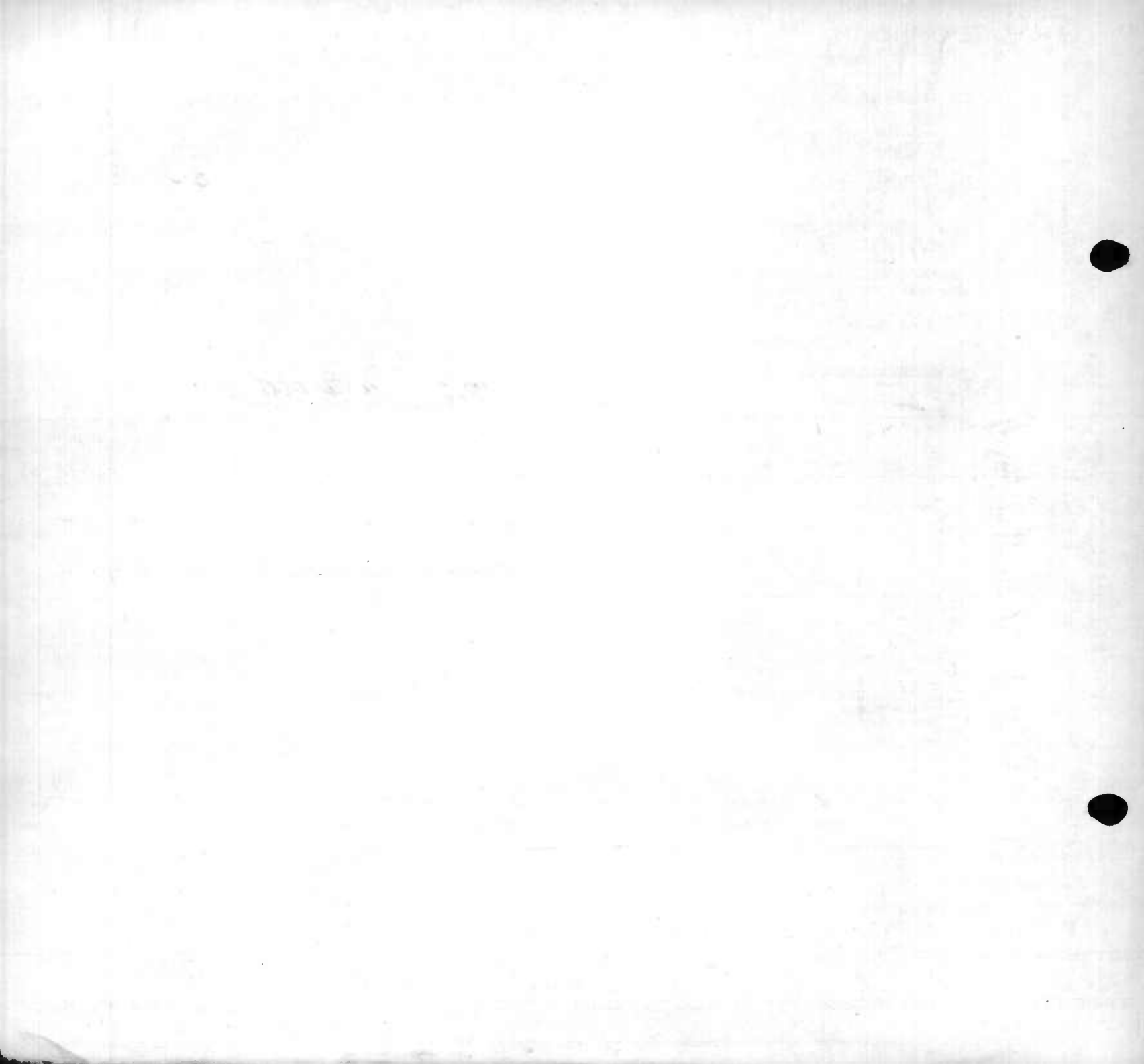
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				BIRTH NO. 55 8011		Registered No. 55 8011	
1. NAME OF DECEASED (Type or Print) JOHN DAVID GROTE				2. DATE AND HOUR OF DEATH 7/30/65 10:50 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) USPHS HOSPITAL BALTIMORE				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE			
5. SEX MALE 6. RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) ---				8. DATE OF BIRTH 30 NOV 55		9. AGE (In years last birthday) 9	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME PALMER GROTE			
14. MOTHER'S MAIDEN NAME CARRIE FIDLER				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ---			
16. SOCIAL SECURITY NO. ---				17. INFORMANT ADDRESS Palmer A. Grote, Bellmeade Ind			
18. 193.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Pulmonary + Cerebral Edema DUE TO (B) Congestive Failure DUE TO (C) Neuroblastoma		INTERVAL BETWEEN ONSET AND DEATH 2 wks 1 yr	
MEDICAL CERTIFICATION				20A. AUTOPSY? (Yes or No) Yes			
19A. DATE OF OPERATION 2				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			
21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (if this hospital) attended the deceased from 29 July 1965 to 30 July 1965 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE J. C. RAHMAN			
23B. DATE SIGNED 7-31-65				23C. PHYSICIAN'S NAME (Type) J. C. RAHMAN			
23D. ADDRESS Colmar Manor, Ind				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 8/3/65				24C. NAME of CEMETERY or CREMATORY St. Lincoln Cemetery			
24D. LOCATION (City, town, or county) (State) Colmar Manor, Ind				25A. DATE REC'D BY HEALTH DEPT. AUG 3 1965			
25B. NAME OF REGISTRAR John B. G. Feltz				25C. FUNERAL DIRECTOR ADDRESS 7 Quaker Lane Hyattsville Ind			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO.		65 8012		CERTIFICATE OF DEATH				Registered No. 65 8012			
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print)		NORMAN S. Hopkins				2. DATE AND HOUR OF DEATH		7-30-65 740 A			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		MD. 99			
37 Mercy Hospital						C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Glen Burnie 52000			
						D. STREET ADDRESS (If rural, give location)		300 3RD AVE. S. E.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.			
M	W	MARRIED	6-28-07	58							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
RETIRED		B & O RR		MARYLAND		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
WALTER Hopkins		Camilla Selby				Yes		WW 11		Mrs. Cecil Hopkins, same as 4	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH					
332 X 19-5-81.1		(A) SUBARACHNOID BLEEDING DUE TO RT CEREBRAL HEMISPHERE				16 hrs					
ANTECEDENT CAUSES		(B) PROBABLE CEREBRAL THROMBOSIS DUE TO				acute					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) HYPERTENSION				chronic					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				nodular cirrhosis (alcoholic)		chronic			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
7-30		EVALUATION OF CEREBRAL SYMPTOMS		YES		YES					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from		July 29 1965		to		July 30 1965					
that (I) (we) last saw the deceased alive on		July 30 1965		and that in (my) (our) opinion death occurred on the date							
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
J. David Nagel M.D.		7-30-65		J. DAVID NAGEL		MERCY HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
Burial		8/2/65		Baltimore National		Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
AUG 8 1965		J. David Nagel		Kirkley Funeral Home, Glen Burnie							

ST. GEORGE'S HOSPITAL
SUBBACHWARD BREEDING

PROBABLE CEMENT THROUGHOUT

INTERSTENSION

NOCTURNAL (alcoholic)

YES

YES

ST. GEORGE'S HOSPITAL
SUBBACHWARD BREEDING

520

1st 30
2nd 50
3rd 100

X

ST. GEORGE'S HOSPITAL

2. DAVID HAGER
ST. GEORGE'S HOSPITAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 8013		CERTIFICATE OF DEATH		65 8013	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) CHARLES BLACK		
2. DATE AND HOUR OF DEATH JULY 31 1965 1 20 A M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY ARUNDEL		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) MILLENSVILLE 62-00		
			D. STREET ADDRESS (If rural, give location) RD X 66 ROL-PARK		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 12/3/1880	9. AGE (In years last birthday) 84	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles Black			14. MOTHER'S MAIDEN NAME Elizabeth Dorsey		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. ?		17. INFORMANT ADDRESS Mrs. Beulah Black, same as 4
18. 433.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) STOKES-ADAMS EPISODE DUE TO (B) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from JULY 30 1965 to JULY 31 1965 , that (I) (we) last saw the deceased alive on JULY 31 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kenneth Mott				23B. DATE SIGNED JULY 31 1965	
23C. PHYSICIAN'S NAME (Type) KENNETH MOTT				23D. ADDRESS M.D. UNIVERSITY HOSPITAL	
24A. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24B. DATE 8/4/65		24C. NAME OF CEMETERY or CREMATORY Ft. Lincoln	
24D. LOCATION (City, town, or county) (State) Bladensburg, Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Kirkley Funeral Home, Glen Burnie	

CHANGES CLERIC

JULY 31 1982

RECEIVED

RECEIVED

RECEIVED

10/2/80

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RECEIVED

JULY 31 1982

JULY 31 1982

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JULY 31 1982

JULY 31 1982

JULY 31 1982

X

JULY 31 1982

CERTIFICATE OF DEATH

Registered No. 65 8014

BIRTH NO. 65 8014		2. DATE AND HOUR OF DEATH 7-29-65 11:35 P. M.	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Virginia Briscoe		A. STATE Maryland	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 732 E. North Avenue - #21202		12. CITIZEN OF WHAT COUNTRY? USA	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 10-1-05
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Factories	9. AGE (In years last birthday) 59
13. FATHER'S NAME Frank Bolling		14. MOTHER'S MAIDEN NAME Sadie Williams	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215 12 3745	
17. INFORMANT ADDRESS RECORDS-BCH-4940 Eastern Avenue-21224			
18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Parkinsonism		CAUSE OF DEATH (A) Cerebral Vascular Accident DUE TO (B) Arteriosclerotic Cardio - DUE TO Vascular Disease (C) 10 years	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-30 1965 to 7-29 1965, that (I) (we) last saw the deceased alive on 7-29 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE J. B. Zachary M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-29-65	
23C. PHYSICIAN'S NAME (Type) Dr. J. B. Zachary		23D. ADDRESS #21224 BCH-4940 Eastern Avenue-Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/4/65	24C. NAME of CEMETERY or CREMATORY Balto. Nat. Cem	24D. LOCATION (City, town, or county) (State) Balto. Md.
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1965	25B. NAME OF REGISTRAR Robert E. Farley	25C. FUNERAL DIRECTOR W. J. Chatman, Jr. 1701 McCulloh St. Balto. Md.	

FUNERAL DIRECTOR: IMPORTANT

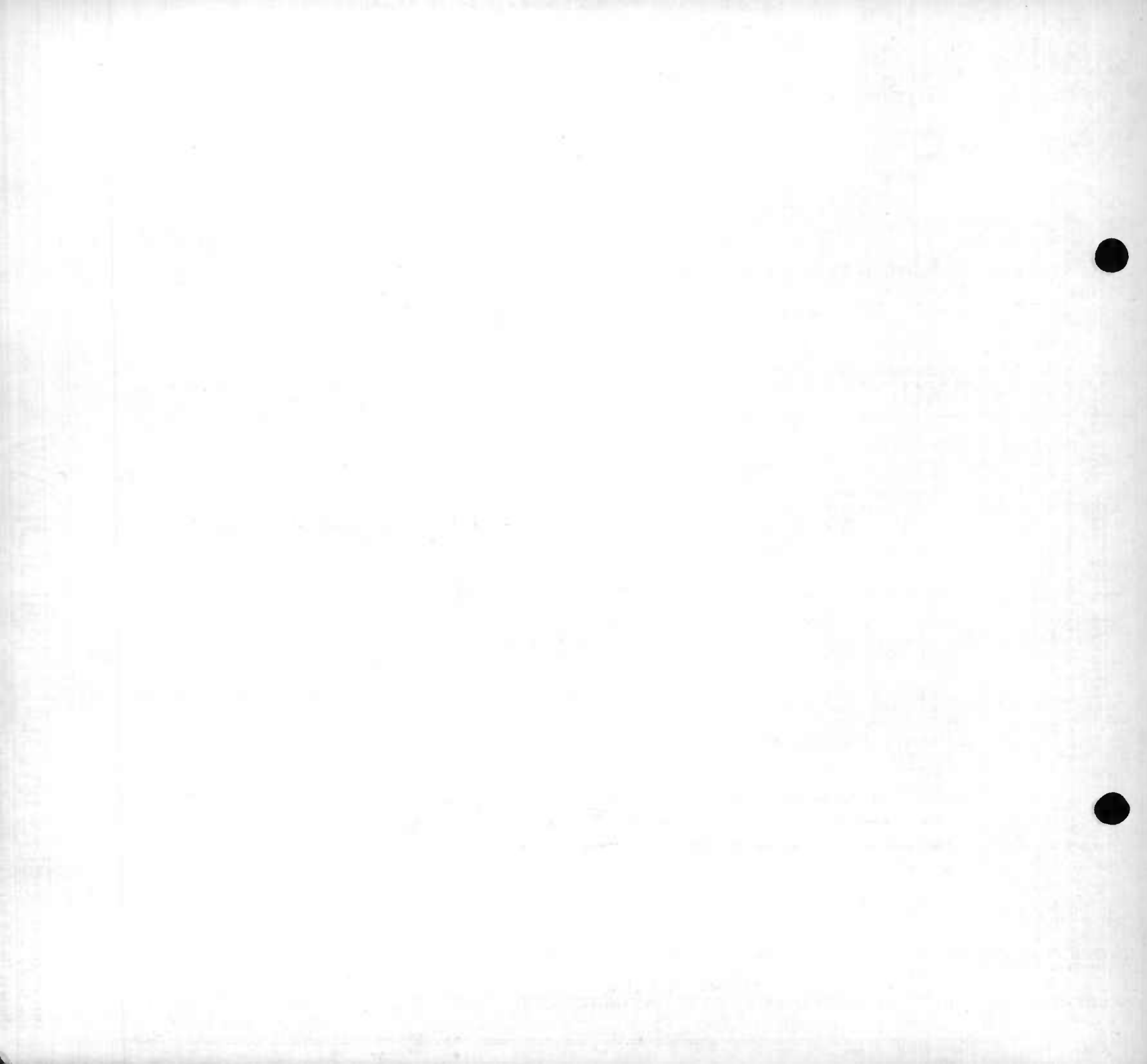
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-0-01

FUNERAL DIRECTOR: IMPORTANT

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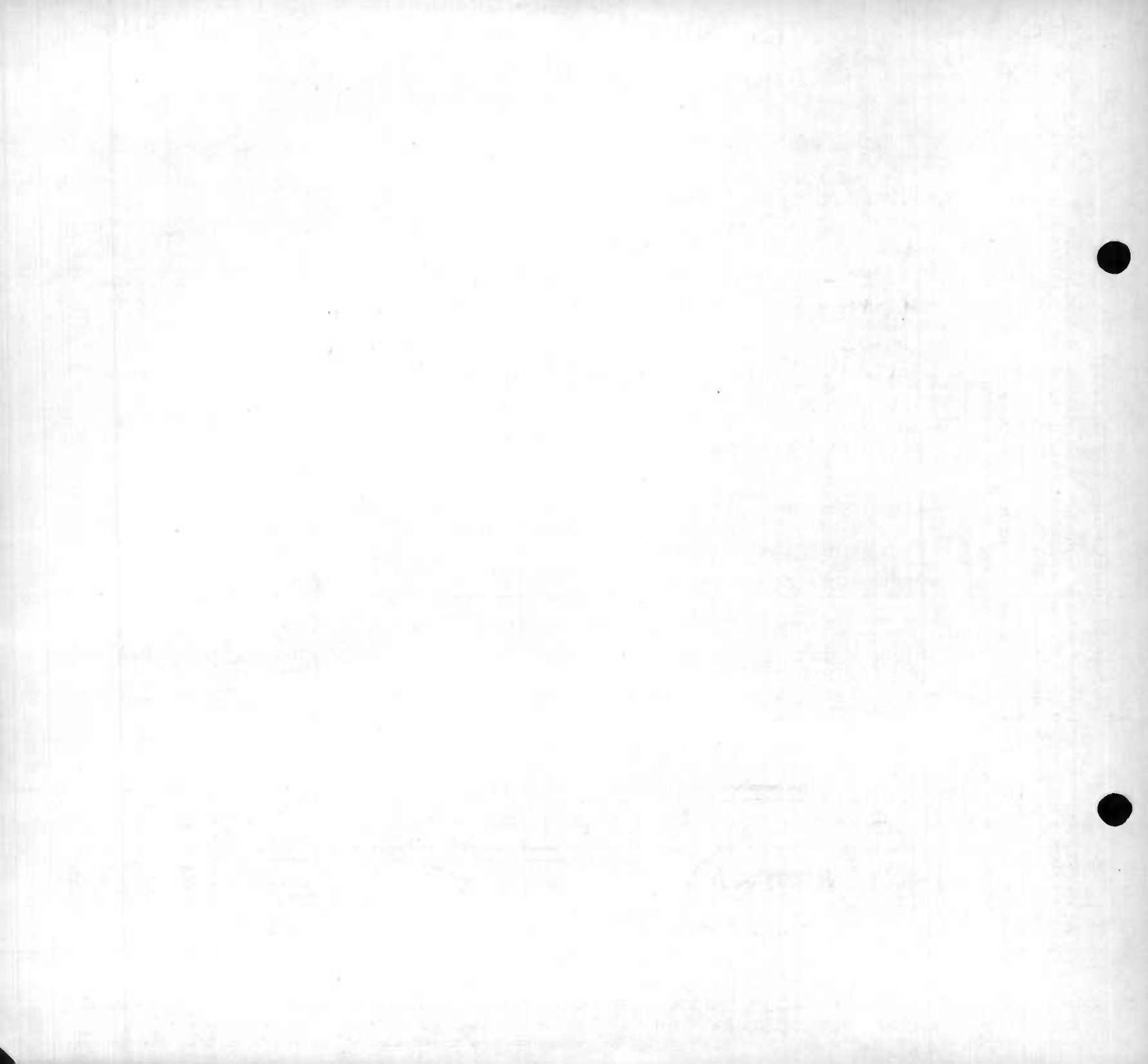
BIRTH NO. 65 8015				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8015	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				m. Sello Vincent		8-1-65 1 2 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
43 S.B.G.H.				38 E. Hamburg St #30			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore Maryland			
				D. STREET ADDRESS (If rural, give location)			
				23-02			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
m	w	Separated	1/15/86	79			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Ret. LABORER		Domino Sugar		Italy			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
UKN.				UKN.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				Guthrie Shiflett		331 E. Hamburg #30	
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO ASCVD		2 weeks	
ANTECEDENT CAUSES				(B) DUE TO CHF			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Pneumonia			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (the) (this hospital) attended the deceased from 7-31-1965 to 8-1-1965, that (I) lost saw the deceased alive on 8-1-1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Dr. Matthew J. Kauf						8-1-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
B		8-4-65		Holy Cross Cemetery		Baltimore #25 Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 3 1965		Robert E. Farber		778 200		130 E. Fort Ave. #30	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

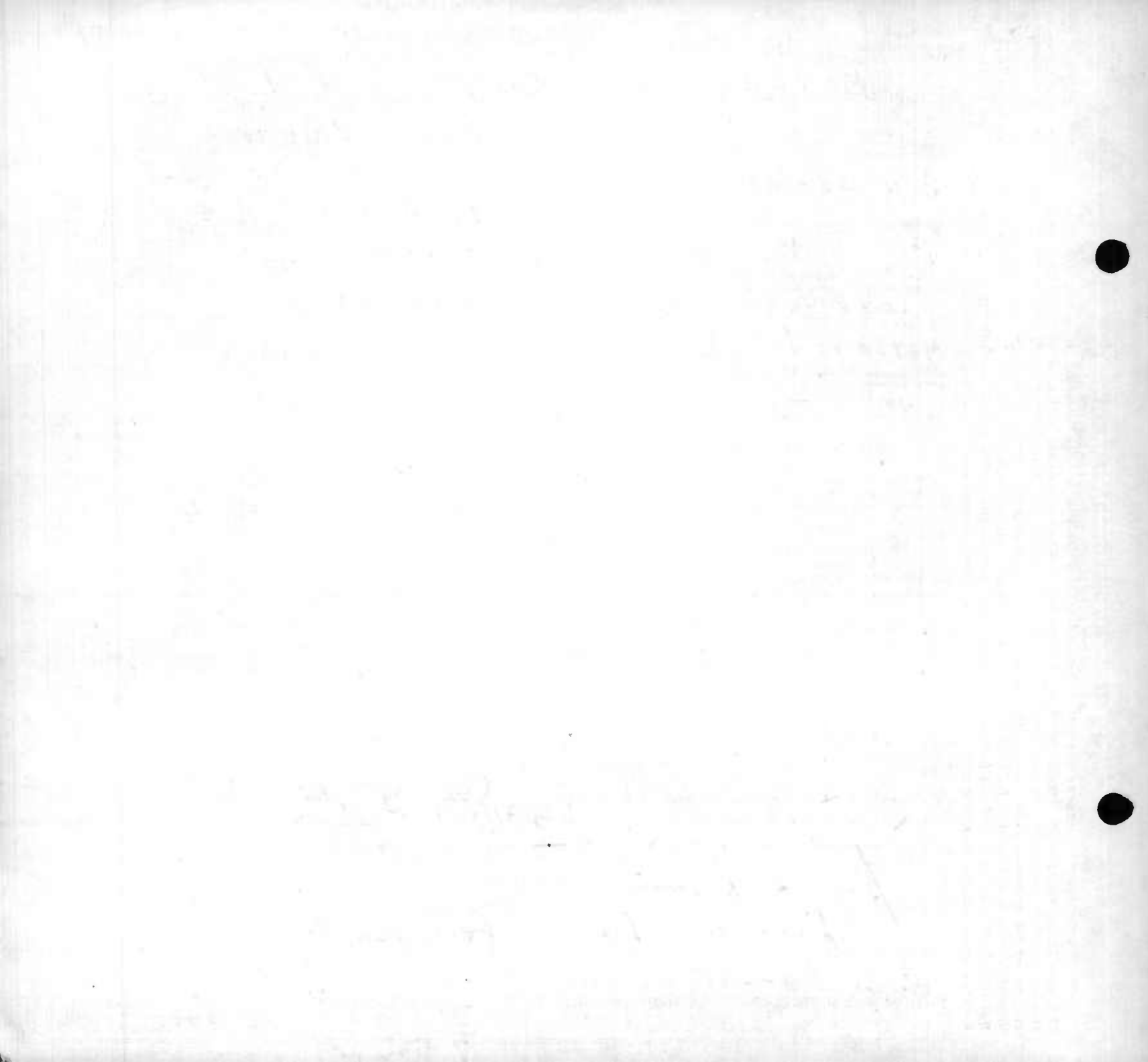
BIRTH NO. 65 8016		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8016	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Christian Roeder			2. DATE AND HOUR OF DEATH Aug. 1, 1965 10:00 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Edgewood Nursing Home 6000 Bellona Avenue			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 400 Cedarcroft Road		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Apr. 13, 1879	9. AGE (In years lost birthday) 86	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Business		10B. KIND OF BUSINESS OR INDUSTRY Lexington Market		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Roeder		14. MOTHER'S MAIDEN NAME Elizabeth Brandau	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Margaret R. Rettberg (Daughter) 405 Croydon Road Balto. 21212	
18. 42211 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from July 13 1965 to Aug 1 st 1965, that (I) (we) last saw the deceased alive on Aug 1 st 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Wm. H. Fusting		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-1-65	
23C. PHYSICIAN'S NAME (Type) Wm. H. Fusting		23D. ADDRESS 4230 Loch Raven Blvd.			
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 8/2/1965		24C. NAME of CEMETERY or CREMATORY Lorrain Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 3 1965		25B. NAME OF REGISTRAR Robert E. Fusting	
25C. FUNERAL DIRECTOR Eugenia K. Seitz		25D. ADDRESS 5209 York Road Baltimore, Md. 21212			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8017				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8017	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MOXLEY - ANNA MARIE				2. DATE AND HOUR OF DEATH 8-1-65 11:40 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS HOSPITAL				A. STATE MD. B. COUNTY BALTIMORE			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Catonville 53-00			
				D. STREET ADDRESS (If rural, give location) 17 SANFORD AVE 21228			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED		8. DATE OF BIRTH 7-22-20	9. AGE (in years last birthday) 45	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Clerk Ret - Dept. Store		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME MOXLEY - John L				14. MOTHER'S MAIDEN NAME CROOK, MARGARET C.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-16-6203		17. INFORMANT ADDRESS John L. Moxley - 17 Sanford Ave			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) GI Hemorrhage, massive				INTERVAL BETWEEN ONSET AND DEATH 6 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. POST-neurotic syndrome (?) (?)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (N) (this hospital) attended the deceased from July 25 1965 to Aug. 1 1965 , that (N) (we) last saw the deceased alive on July 31 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (N) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Alexander R. Lim				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Aug. 1, 1965	
23C. PHYSICIAN'S NAME (Type) Alexander R. Lim				23D. ADDRESS Bon Secours Hosp. Balto. 23			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-4-65		24C. NAME OF CEMETERY or CREMATORY Cathedral Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Farley Funeral Home Catonsville, Md.			



1

65 8018

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65 8018

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LUCILLE

McRAE

2. DATE AND HOUR PRONOUNCED DEAD

July 30, 1965

6:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

660 W. Fayette Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

Dec 18, 1921

9. AGE (In years
last birthday)

33 1/4

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Frank Shaw

14. MOTHER'S MAIDEN NAME

Mary

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

David McRae 660 Fayette st.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Lobar pneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/30/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Aug 4, 1965

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

Balto, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 3 1965

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

Geo. G. Kelson 1348 N. Calhoun st

ADDRESS

VALLEY PROPERTIES

PROPERTIES

PROPERTIES

PROPERTIES

PROPERTIES

PROPERTIES

PROPERTIES

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PROPERTIES

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARLENE

STEWART

2. DATE AND HOUR PRONOUNCED DEAD

August 1, 1965

4:20 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Fayette Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

M

8. DATE OF BIRTH

Oct 28, 1941

9. AGE (In years
last birthday)

23

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laundry

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Taylor

14. MOTHER'S MAIDEN NAME

Martha Haskins

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Martha Haskins 1728 E. Fayette st.

18. E 816.41

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple Traumatic Injuries.
DUE TO

(B) DUE TO

(C) DUE TO

II
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Dorsey and Ridge Roads, A.A.Co.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

8

1

'65

A.

m.

21E. INJURY OCCURRED

WHILE AT
WORK☐NOT WHILE
AT WORK☒

21F. HOW DID INJURY OCCUR?

Auto-Auto collision

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/1/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

Aug 4, 1965

23C. NAME of CEMETERY or CREMATORY

Arbutus Mem Park

23D. LOCATION

(City, town, or county)

(State)

Arbutus Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 3 1965

24B. NAME OF REGISTRAR

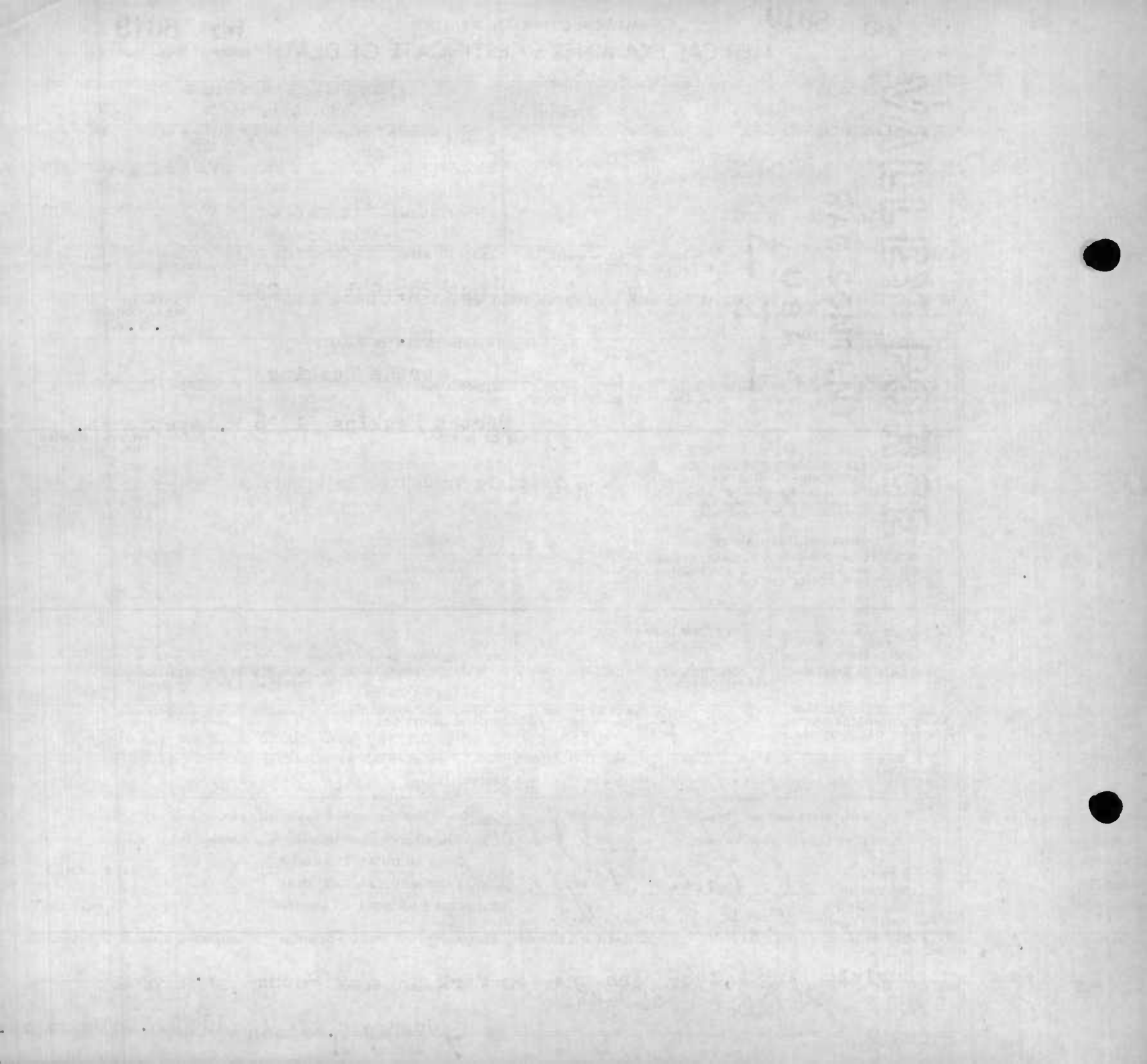
Robert E. Jenkins

24C. FUNERAL DIRECTOR

George G. Kelson

ADDRESS

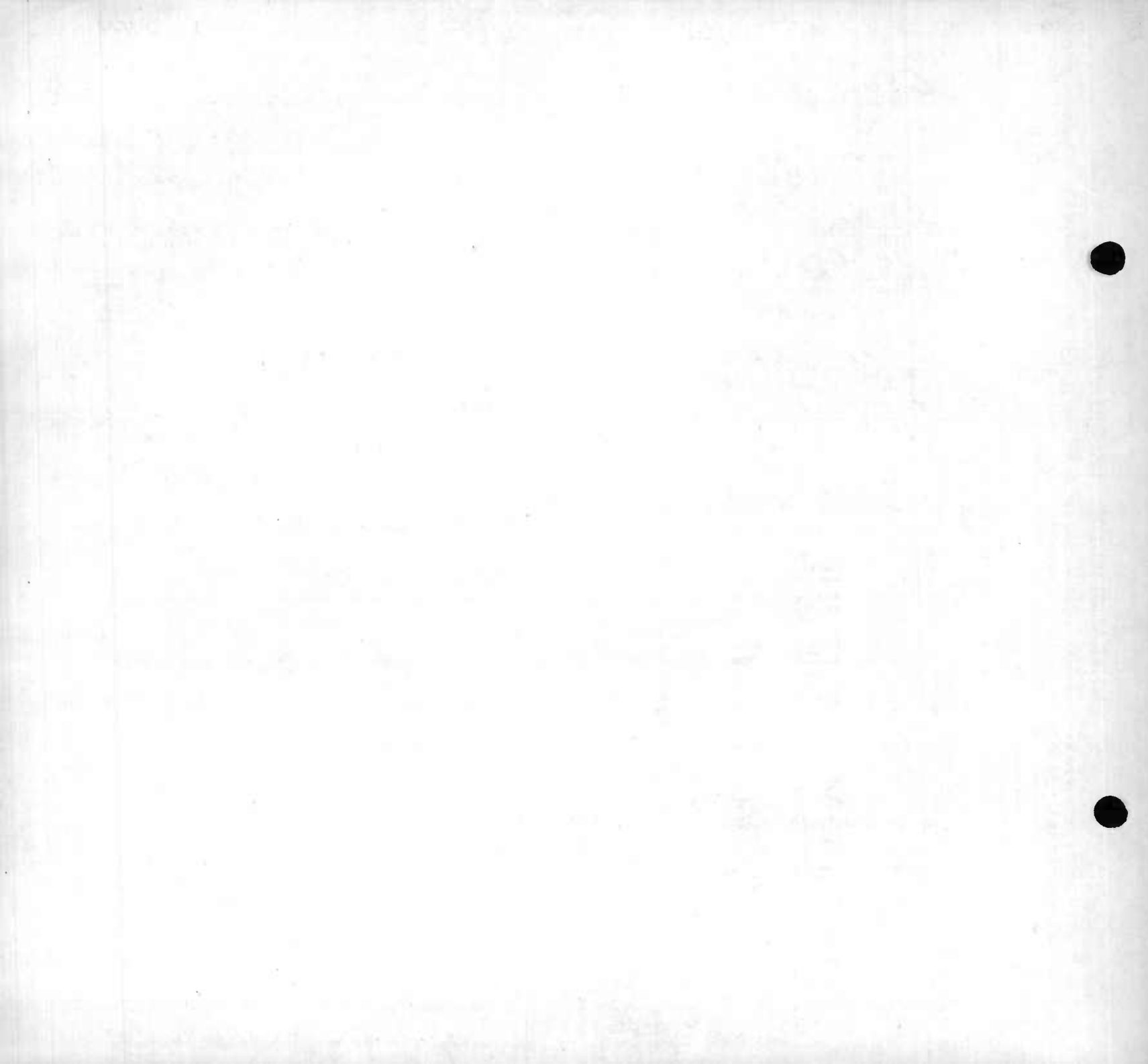
1348 N. Calhoun st.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

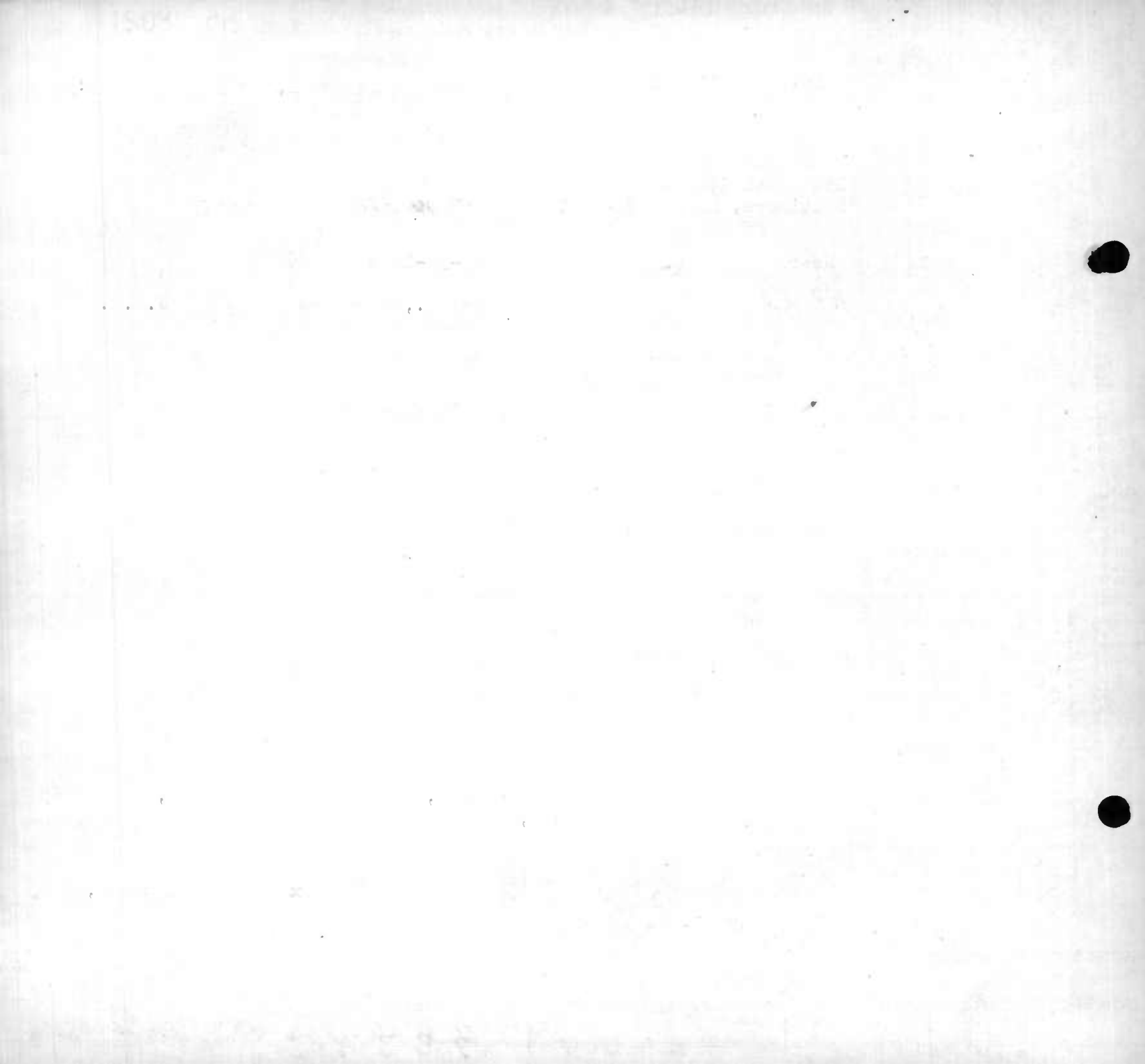
BIRTH NO. 65 8020		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 8020	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Lanier, Father</i>			
2. DATE AND HOUR OF DEATH <i>7-31-65 8:30 P. M.</i>				3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>George Washington Carver Nursing Home</i>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>8</i> B. COUNTY <i>Bethune Rd</i>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore, Maryland #25</i>				D. STREET ADDRESS (If rural, give location) <i>815 Bethune Rd 25-32</i>			
5. SEX <i>male</i>	6. RACE <i>negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>3-15-1929</i>	9. AGE (In years last birthday) <i>56</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>north, Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Sole Lanier</i>				14. MOTHER'S MAIDEN NAME <i>Un Known</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>un Known</i>				16. SOCIAL SECURITY NO. <i>245-01-2900</i>		17. INFORMANT <i>880290 Washington Carver Nursing Home</i>	
18. <i>443X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO <i>CVA - Cerebral Hemorrhage</i> (B) DUE TO <i>Hypertensive Cardiovascular Disease Unknown</i> (C) <i>Chronic Brain Syndrome</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>Unknown</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>May 4</i> 19 <i>65</i> to <i>19</i> 19 <i>65</i> that (I) (we) last saw the deceased alive on <i>July 30</i> 19 <i>65</i> and that (in my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>E. E. Holt</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>8/2/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>E. E. Holt</i>				23D. ADDRESS M.D. <i>3715 Liberty Hts. Ave. Baltimore, Md</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Aug 4, 1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Auburn</i>		24D. LOCATION (City, town, or county) (State) <i>Balto Md</i>	
25A. DATE REC'D BY HEALTH DEPT <i>AUG 3 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor M.D.</i>		25C. FUNERAL DIRECTOR <i>Mrs. W. Kelown</i>		ADDRESS <i>1348 N. Calhoun</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

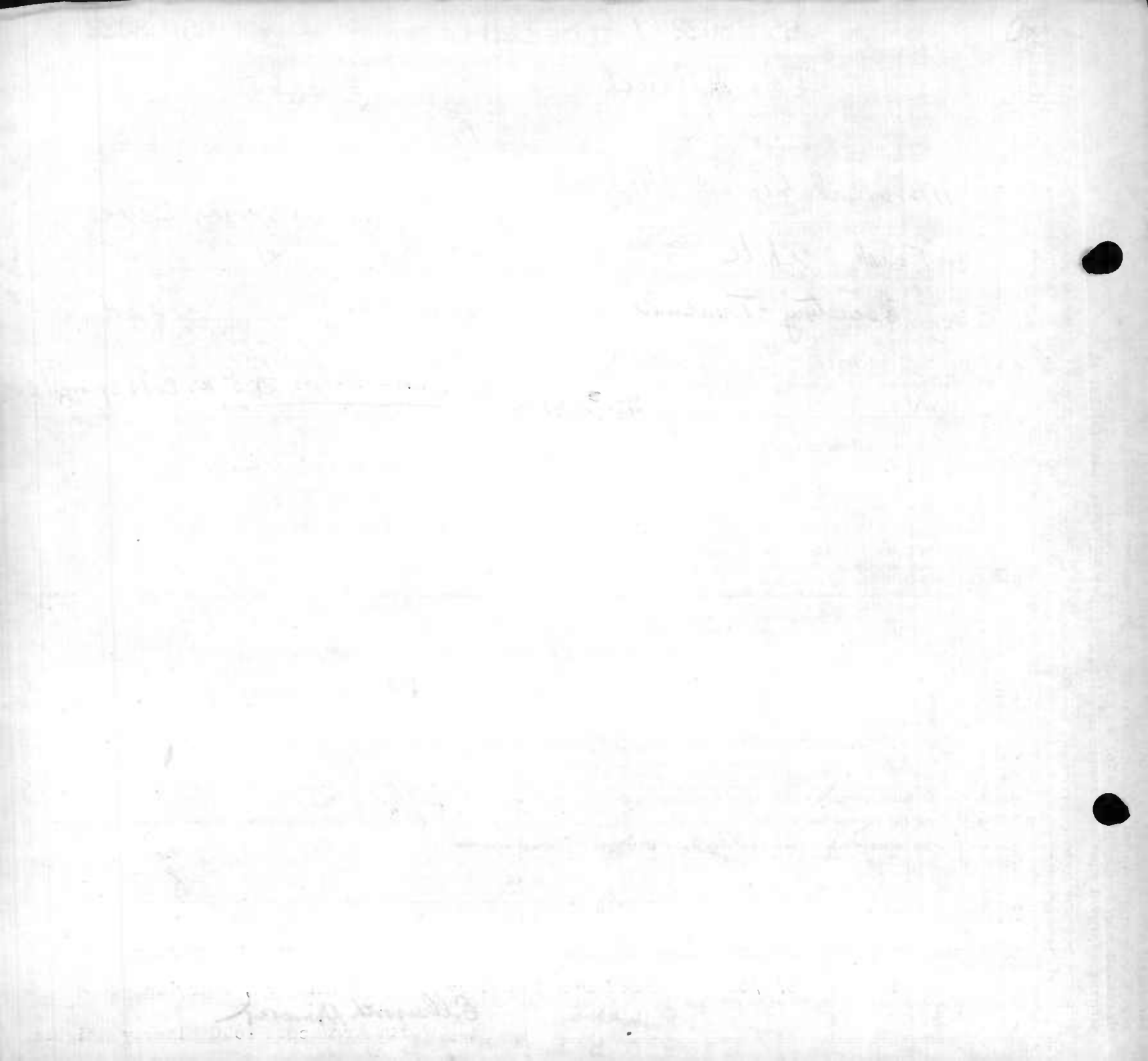
BIRTH NO. 65 8021				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8021	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Clifford Robinson				2. DATE AND HOUR OF DEATH August 1, 1965 3:30 AM.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland 21217				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 17-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1328 Ething Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11-30-1899	9. AGE (In years lost birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Walter Robinson			14. MOTHER'S MAIDEN NAME Ida		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO.			17. INFORMANT Louise Robinson - 1328 Ething St				
18. 493X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Severe dehydration (A) DUE TO Pneumonia (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 3, 1965 to August 1, 1965 , that (I) (we) last saw the deceased alive on August 1, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Baldino Tayas, Jr. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED August 2, 1965			
23C. PHYSICIAN'S NAME (Type) BALDINO TAYAS, JR. M.D.				23D. ADDRESS 1514 Division Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/5/1965		24C. NAME OF CEMETERY or CREMATORY Pleasant Rest		24D. LOCATION (City, town, or county) (State) Jourison Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1965				25C. FUNERAL DIRECTOR Earl Gilmore - 1827 W. North Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

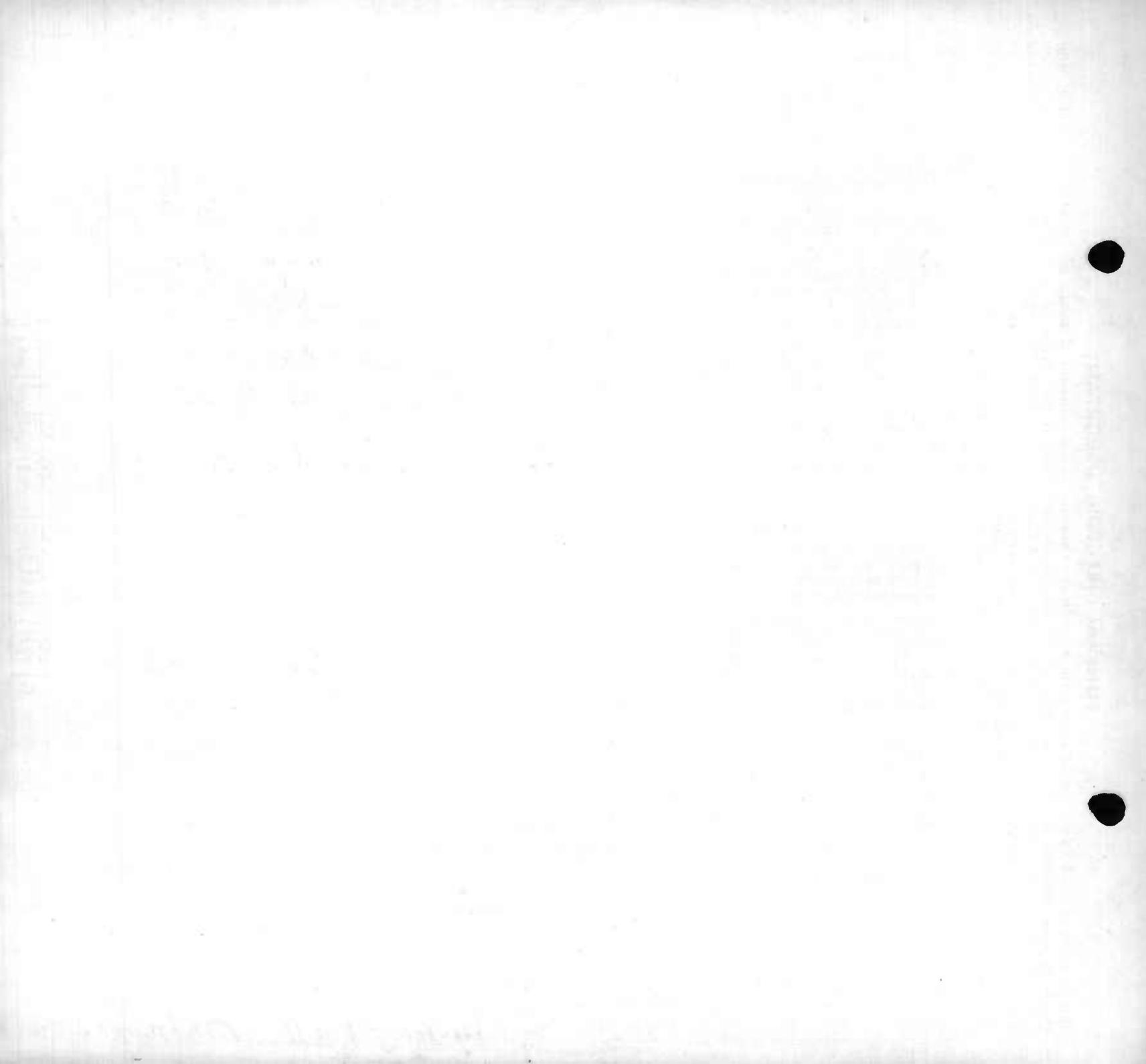
BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 8022					CERTIFICATE OF DEATH					Registered No. 65 8022				
1. NAME OF DECEASED (Type or Print) <i>Ida May Rauch</i>										2. DATE AND HOUR OF DEATH <i>8-2-65</i> <i>12³⁰ A</i> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland General Hospital</i>										4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md.</i> B. COUNTY <i>15-10</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>3905 W. Cold Spring Lane</i>				
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i>		8. DATE OF BIRTH <i>2-20-84</i>		9. AGE (In years last birthday) <i>81</i>		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary - Treasurer</i>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Benjamin B. Rauch</i>					14. MOTHER'S MAIDEN NAME <i>Emma Cooper</i>					17. INFORMANT <i>Mrs EMMA DAVIES 3905 W. Cold Spring Lane</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>					16. SOCIAL SECURITY NO. <i>215-70-4674</i>		17. ADDRESS <i>Hospital Chat</i>							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of colon</i>										CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(A) DUE TO				
										(B) DUE TO				
										(C) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION <i>2</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>8-1-65</i> to <i>8-2-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <i>[Signature]</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <i>8-2-65</i>				
23C. PHYSICIAN'S NAME (Type) <i>[Signature]</i>					23D. ADDRESS M.D.									
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/4/65</i>		24C. NAME of CEMETERY or CREMATORY <i>Oak Lawn Cemetery</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>							
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 3 1965</i>					25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>					25C. FUNERAL DIRECTOR <i>Ellsworth Armacost</i>				
					ADDRESS <i>4600 Liberty Heights</i>									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 65 8023	
BIRTH NO. 60-26071		CERTIFICATE OF DEATH			
M.E. CASE NO. 65 8023		1. NAME OF DECEASED (Type or Print) McLAUGHLIN DANIEL Jr.		2. DATE AND HOUR OF DEATH 3:50 a.m. 8/1/65	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital Maryland University Hosp.		D. STREET ADDRESS (If rural, give location) 928 West North Ave. Baltz		13-02	
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) —	8. DATE OF BIRTH 9/15/60	9. AGE (In years last birthday) 4 yrs	If Under 1 Yr. Months: Days: Hours: Min. 9MO
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John McLaughlin		14. MOTHER'S MAIDEN NAME Helen Assington		15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mother		ADDRESS above address.	
18. 010X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Meningoencephalitis, probably TBC. (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 22.50 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work Not While At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/8/65 19 to 8/1/65 19 that (I) (we) last saw the deceased alive on 8/1/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE D. Abdul Latif M.D. Attending Phys. Med. Director Staff Phys.				23B. DATE SIGNED 8/1/65	
23C. PHYSICIAN'S NAME (Type) D.I. ABDUL-LATIF		23D. ADDRESS Univ. Hosp. Box 199			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-4-65		24C. NAME OF CEMETERY or CREMATORY Balto Nat	
24D. LOCATION (City, town, or county) (State) Balto Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 3 1965			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS MORTON & RYAN 1701 Laurens St.			



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM

KELLY (KELLEY)

2. DATE AND HOUR PRONOUNCED DEAD

July 31, 1965

5:05 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2210 Bryant Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

4-3-1915

9. AGE (In years
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Balt. Gas & Elec.

11. BIRTHPLACE (State or foreign country)

Cumber City, Tenn

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNK.

14. MOTHER'S MAIDEN NAME

UNK.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL
SECURITY NO.

335-12-9475

17. INFORMANT

Delores Anderson

ADDRESS

2201 1/2 N. E. / Ten Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

Spinal cord compression

(A)
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Fracture of crevical vertebrae

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Reisterstown Rd. & Bryant Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
7 31 '65 A

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Pedestrian Struck by auto.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/31/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-4-65

23C. NAME OF CEMETERY or CREMATORY

B.A.H. NATIONAL B.A.H.

23D. LOCATION

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 3 1965

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

Mortenson & Dyett

ADDRESS

1701 Laurens St.

CONTENTS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

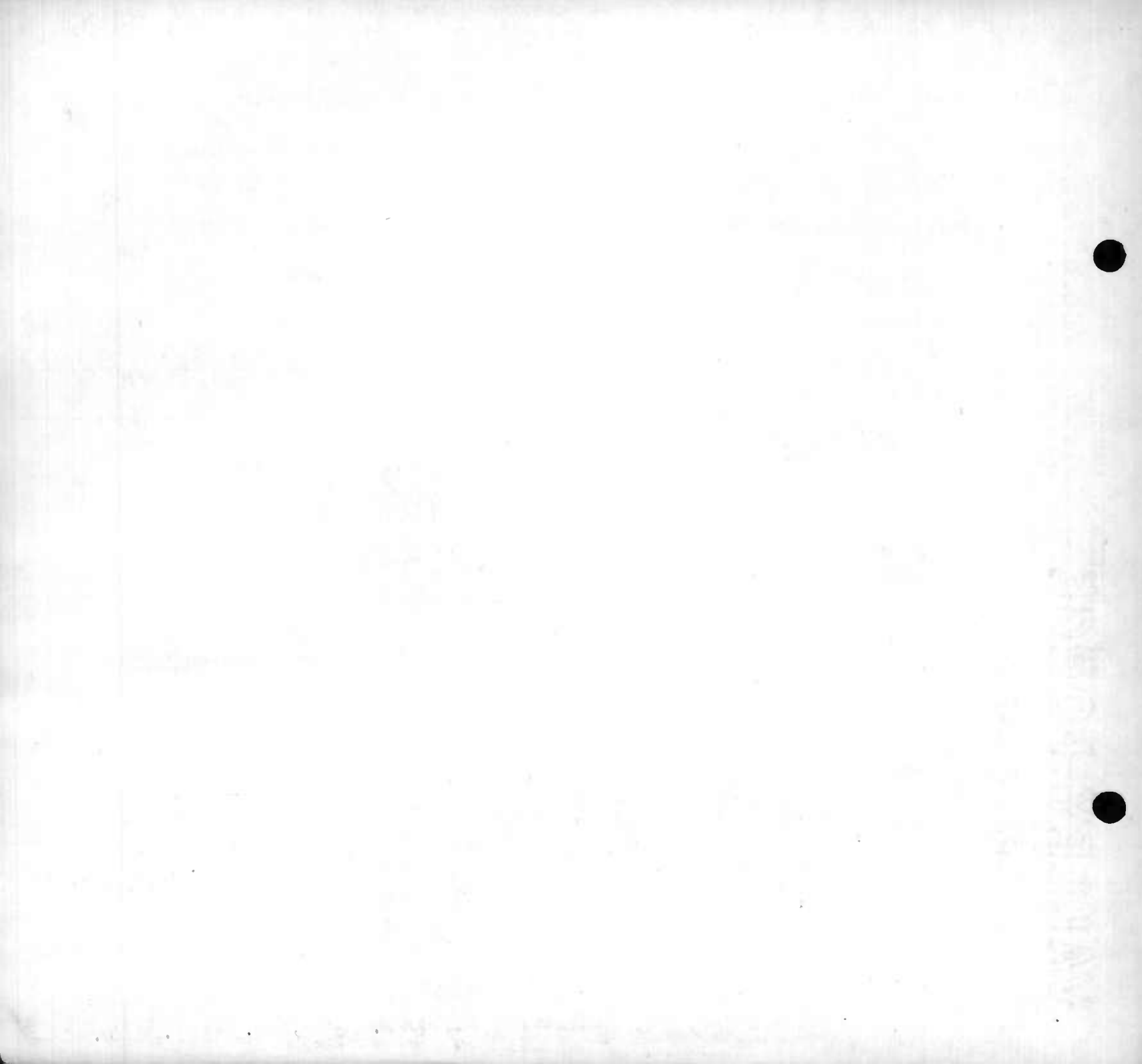
BIRTH NO. 65 8025				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8025	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print) SIMMONS, HENRY						7-31-65 10:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
36 FRANKLIN SQUARE HOSPITAL				MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
				D. STREET ADDRESS (If rural, give location)			
				1924 W. BALTIMORE ST 23			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
M	N	MARRIED	7-3-05	60			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
LABORER				FLORIDA		U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
SIMMONS ?				LUCILLE (Does not REMEMBER)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
UNKNOWN				218-03-8946		HOSPITAL RECORD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 7-31-65 19 to 7-31 1965, that (I) (we) lost saw the deceased alive on 7-31 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
JACINTO V. DE BORJA						7-31-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
JACINTO V. DE BORJA				FRANKLIN SQ - HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		8-4-65		Arbutus Mem Pl.		Arbutus Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 3 1965		Robert E. Jackson		MORTON + DYE		1701 Laurens ST	

Interpretation of the text

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8026				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8026	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>ELLA U Keeley</i>				2. DATE AND HOUR OF DEATH <i>July 31, 1965</i> <i>7:45 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Little Sisters of the Poor</i> <i>1200 Valley St,</i> <i>Baltimore Md 21202</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>MD.</i>		B. COUNTY <i>10-01</i>	
5. SEX <i>F</i>				6. RACE <i>W</i>			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH <i>5.15.1887</i>		9. AGE (In years last birthday) <i>87 7/8</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>floor lady - Net factory</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	
13. FATHER'S NAME <i>Peter Keeley</i>				14. MOTHER'S MAIDEN NAME <i>HONORA Flaherty</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>215-07-0274 A</i>		17. INFORMANT <i>Little Sisters of the Poor</i>	
18. <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Pulmonary edema</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>A.S.C.V.D</i> <i>Old age</i>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>1964</i> to <i>July 31</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>July 31</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Stanley Ankudas</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>Aug. 65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Stanley Ankudas</i>				23D. ADDRESS <i>1802 W. BALTIMORE ST.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/3/65</i>		24C. NAME of CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 3 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>John A. Moran, Inc. 3000 E. Balto. St</i>			



B623

1		65 8027		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No. 65 8027	
BIRTH NO.				M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD					
GERTRUDE BURKETT				8-1-65				3:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland				B. COUNTY	
531 PRESTMAN STREET				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)				14-03	
				D. STREET ADDRESS (If rural, give location)				531 Presstman Street	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		Colored				May 24-1898		67	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)	
Housewife								Howard Co. Md.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?	
William McDaniel				Elizabeth Young				U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No.						Lachar Simon			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO				Congestive heart failure	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO				Arteriosclerotic cardiovascular disease	
(C) DUE TO									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				No					
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
22.		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		PETER W. RIECKERT, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		8-2-65	
EXAMINER'S NAME (Type)				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)			
Burial		8-4-1965		Mt Auburn Cem		Baltimore			
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS			
AUG 3 1965		Robert E. Farkas		Choy Wilson - 1001 Broadway					

WALLACE HOBBS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 8028

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARGUERITE HONASKI

2. DATE AND HOUR PRONOUNCED DEAD

8-1-65

8:50 P M

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

ST. AGNES HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Ellicott City

D. STREET ADDRESS (If rural, give location)

329 S. St. John's Lane

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Nov. 2, 1929

9. AGE (In years
last birthday)

35

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

New Jersey

12. CITIZEN OF
WHAT COUNTRY?
United States

13. FATHER'S NAME

Otto Johnson

14. MOTHER'S MAIDEN NAME

Marguerite Dorion

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.
220-22-4622

17. INFORMANT

ADDRESS

Dr. Raymond J. Honaski, 329 S. St. Johns Lane

18. CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenio, etc. It means the disease,
injury or complication which caused death.)(A) Carbon monoxide poisoning
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Garage

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

329 S. St. John's Lane

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
Between 3:00
8 1 '65 7:30 PM

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Inhaled carbon monoxide

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

PETER W. RIECKERT, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

8-2-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Aug. 4, 1965

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cemetery Baltimore, Maryland

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 3 1965

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

Harry H. Witzke, 321 Columbia Pike, Ellicott City, Md.

ADDRESS

WALL FORT

RECEIVED

1944

1944

1944

1944

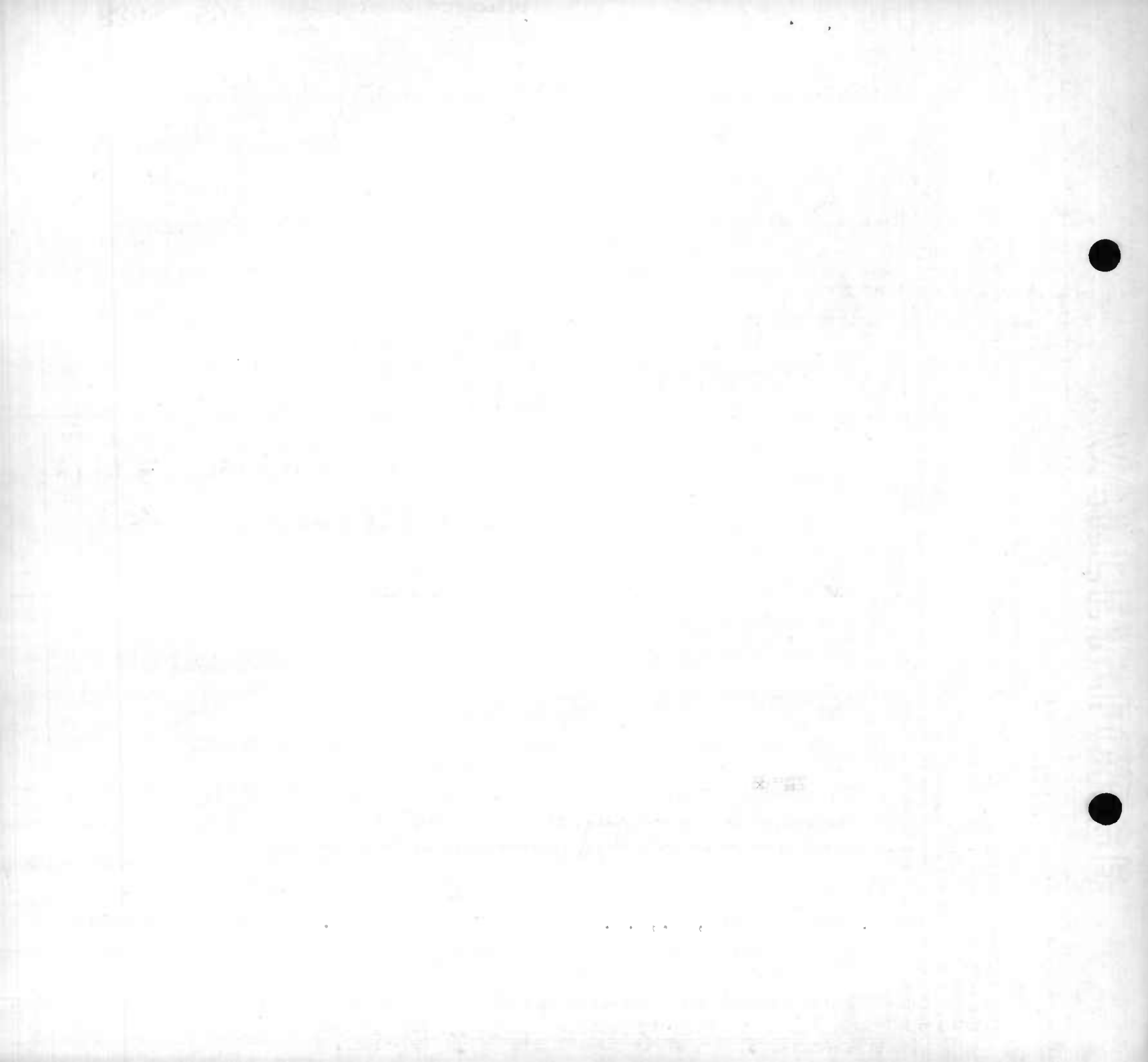
1944

1944

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8029	
BIRTH NO.				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Haupp, Miss Johann Marie</u>				July 31, 1965 5 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Keswick Home</u>				A. STATE <u>Maryland</u> B. COUNTY <u>13-09</u>	
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
				D. STREET ADDRESS (If rural, give location) <u>700 W. 40th. St.</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>Oct. 15, 1883</u>	9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory Forelady</u>			11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13. FATHER'S NAME <u>George F. Haupp</u>			14. MOTHER'S MAIDEN NAME <u>Johanna Louise Mueller</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>215-63-6441A</u>		
			17. INFORMANT ADDRESS <u>Helen Keller, RN. - Keswick</u>		
18. <u>334X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>Broncho pneumonia</u> DUE TO (B) <u>Cerebral atherosclerosis</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>10 yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Dec. 12, 1956</u> 19 to <u>July 31, 1965</u> , that (I) (we) last saw the deceased alive on <u>July 31, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E. Hunter Wilson, Jr.</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>8-2-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>E. Hunter Wilson, Jr., M.D.</u>				23D. ADDRESS <u>700 West 40th. Street The Keswick</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/4/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Western</u>	
24D. LOCATION (City, town, or county) (State) <u>Bal to. Md</u>		24E. DATE REC'D BY HEALTH DEPT. <u>AUG 3 1965</u>			
25A. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>W. J. F. Home 4101 E. Edmonson</u>	



65 8030		BALTIMORE CITY HEALTH DEPARTMENT		65 8030	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
ANNA LEE LAND			July 29, 1965 2:20 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 574 W. Preston St.			A. STATE Maryland		
			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 574 W. Preston St.		
5. SEX female	6. RACE colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (in years last birthday) 57	10. Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> </div> <div style="width: 50%;"> <p>(A) Fatty metamorphosis of the liver DUE TO</p> <p>(B) DUE TO</p> <p>(C) DUE TO</p> </div> </div>					
<p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER		8-16-65	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY OR CREMATORY	
		8/3/65		BALTIMORE BOARD OF MARYLAND	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR	
AUG 3 1965		Robert E. Farley, M.D.		UNIVERSITY MEDICAL SCHOOL	
				MORTUARY SERVICE - BCHD	

WATLEY FORDGE

RAPOCONE NT

US A

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

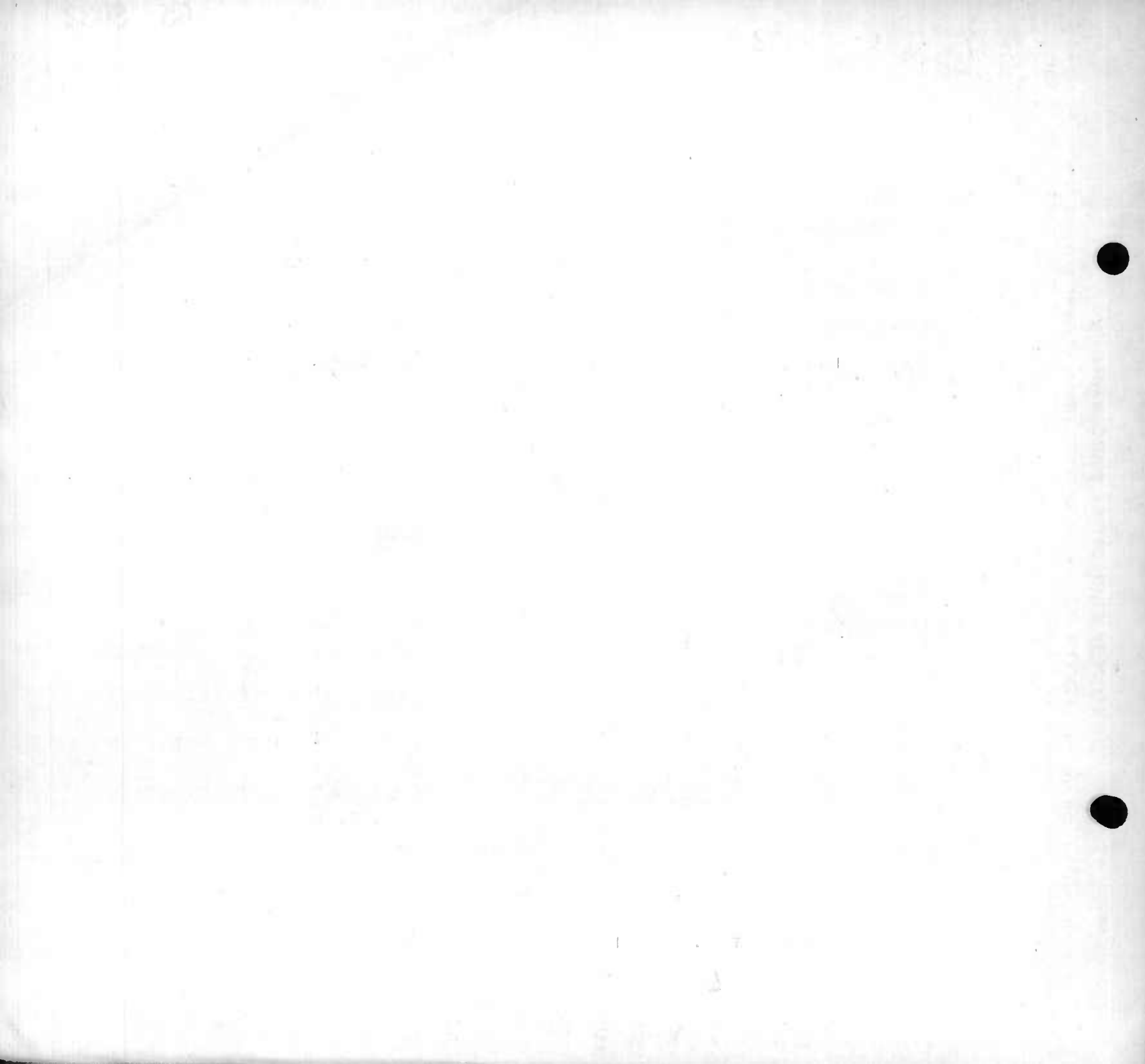
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <u>65-18513</u>		CERTIFICATE OF DEATH		65 8031	
M.E. CASE NO. <u>65 8031</u>					
1. NAME OF DECEASED (Type or Print) <u>Baby Hiri NAROWANSKI</u>		2. DATE AND HOUR OF DEATH <u>7/27/65 @ 8am</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>MARYLAND GENERAL Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>- BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>8629 Oak Rd.</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>7/26/65</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <u>9 52</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>VERNON JOSEPH NAROWANSKI</u>		14. MOTHER'S MAIDEN NAME <u>MARIE FRANCES PERRERA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT ADDRESS <u>Mother Same</u>	
18. <u>773.51</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>RESPIRATORY FAILURE</u> DUE TO (B) <u>PREMATURITY</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>9 hrs 52 min</u>	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>7/26 1965</u> to <u>7/27 1965</u> , that (I) (we) last saw the deceased alive on <u>7/27 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Donald L. Lohat</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>7/27/65</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>AUG 2 1965</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MORTUARY SERVICE - BCHD</u>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH. DEPT. <u>AUG 3 1965</u>			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 8032		CERTIFICATE OF DEATH		65 8032	
M.F. CASE NO. 65 8032		1. NAME OF DECEASED (Type or Print) BIRD, HERMINE		2. DATE AND HOUR OF DEATH 7/31/65 11 05/A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-13 D. STREET ADDRESS (If rural, give location) 2804 SANTA FE AVE.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	B. DATE OF BIRTH 12/20/03	9. AGE (In years lost birth day) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME KARL GRIMM		14. MOTHER'S MAIDEN NAME ANNA BROESSEL		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Respiratory arrest		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Pulmonary edema DUE TO			
		(C) Generalized carcinomatosis DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Arterial insufficiency to @ leg.			
19A. DATE OF OPERATION 3 7/27/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED arterial insufficiency		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/12 19 65 to 7/31 19 65 , that (I) (we) last saw the deceased alive on 7/31 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Margaret A. Dennis		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 31, 1965	
23C. PHYSICIAN'S NAME (Type) MARGARET A. DENNIS		23D. ADDRESS The Johns Hopkins Hospital.			
24A. BURIAL CREMATION, REMOVAL (Specify) AUG 2 1965		24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL		24B. LOCATION (City, town, or county) (State) MORTUARY SERVICE - BCHD	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1965		25B. NAME OF REGISTRAR Robert E. Falker		25C. FUNERAL DIRECTOR ADDRESS	



65 8033

BALTIMORE CITY HEALTH DEPARTMENT

65 8033

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ERNEST WILLIAM BOOTH

2. DATE AND HOUR PRONOUNCED DEAD

8-1-65

1:45 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1018 N. Charles Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Nov. 25, 1895

9. AGE (In years
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cost Acct.

10B. KIND OF BUSINESS OR INDUSTRY

B & O R R

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert Booth

14. MOTHER'S MAIDEN NAME

Hendricka Vandermast

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

705-05-5390

17. INFORMANT

ADDRESS

Mr. Robert V. Booth, 1307 E. Belvedere Ave.

18. 423.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

PETER W. RIECKERT, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

8-2-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

8/5/65

23C. NAME of CEMETERY or CREMATORY

PARKWOOD CEMETERY

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MD.

24A. DATE REC'D BY HEALTH DEPT.

AUG 3

1965

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

ADDRESS

LEONARD J. RUCK, INC., BALTO., MD. 21214

WALLLEY POLICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8034				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 8034	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) WALTER J. ABERTS		2. DATE AND HOUR OF DEATH 8-1-1965		5:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital				Maryland		Baltimore		Baltimore	
5. SEX Male				6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 9-15-05	
9. AGE (In years lost birthday) 59				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bakery		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Aberts				14. MOTHER'S MAIDEN NAME Mary C. Grail		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-05-0947	
17. INFORMANT Ethel L. Aberts				18. CAUSE OF DEATH		19. ADDRESS 7803 Chestnut Ave			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHOGENIC ADENOCARCINOMA OF THE LUNG & METASTASIS TO THE LIVER & HEART				INTERVAL BETWEEN ONSET AND DEATH mos.					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 8-1-65				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8-1-65 to 8-1-65 , that (I) (we) last saw the deceased alive on 8-1-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE Jose S. Mancoske				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-1-65			
23C. PHYSICIAN'S NAME (Type) Jose S. Mancoske M.D.				23D. ADDRESS Church Home & Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 8/4/65		24C. NAME of CEMETERY or CREMATORY Cedar Hill		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1965				25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc		ADDRESS 5305 Harford Rd	

Handwritten notes, possibly a list or index, located in the upper left quadrant of the page.

Handwritten notes, possibly a list or index, located in the upper right quadrant of the page.

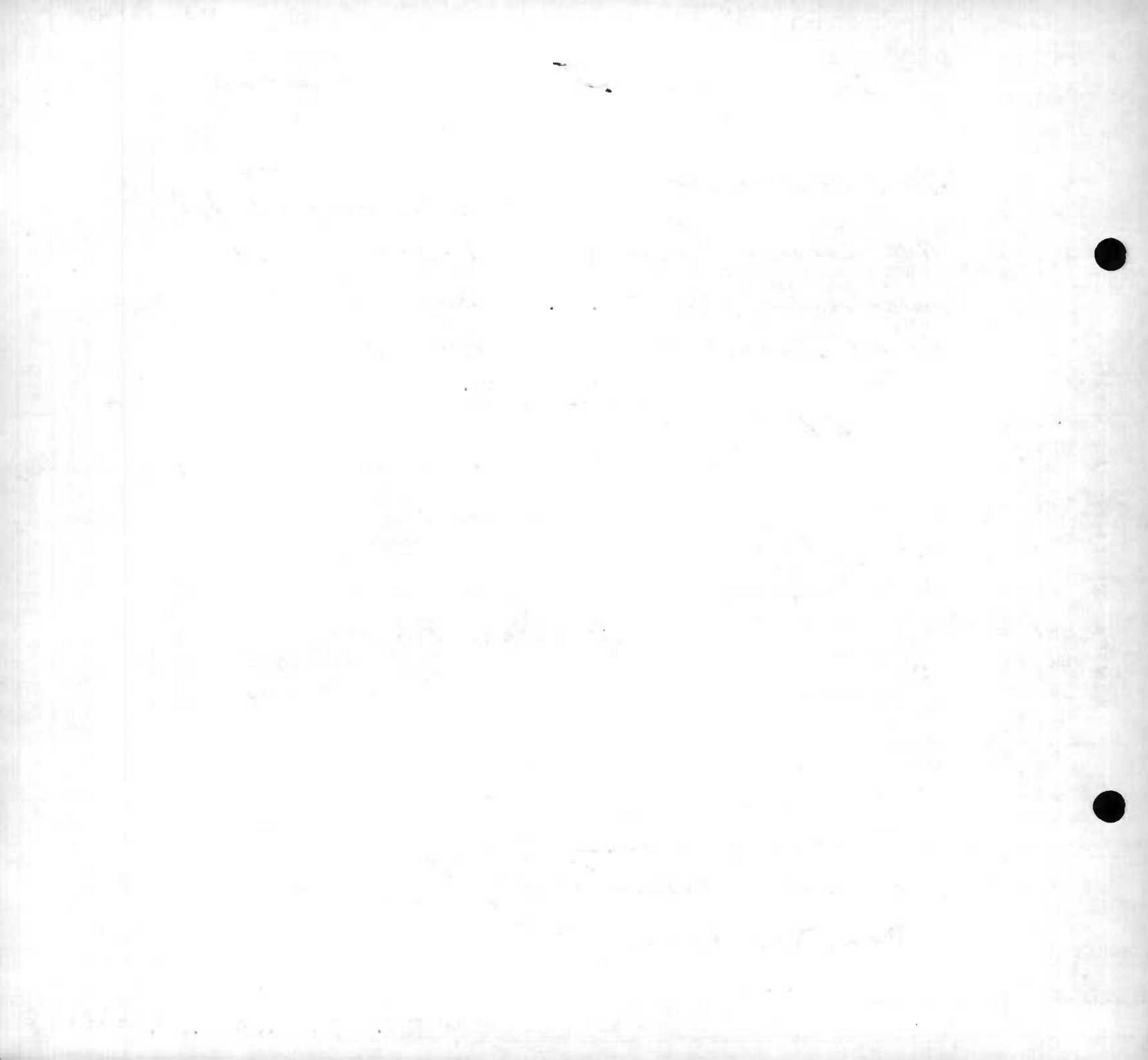
Handwritten notes, possibly a list or index, located in the lower left quadrant of the page.

Handwritten notes, possibly a list or index, located in the lower right quadrant of the page.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
65 8035					65 8035					
BIRTH NO.					CERTIFICATE OF DEATH					
M.E. CASE NO.					Registered No.					
1. NAME OF DECEASED (Type or Print) <i>Darmsteadt, Bernard ALBERT</i>					2. DATE AND HOUR OF DEATH <i>8-2-65 1:50 P.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Mercy Hospital, Balto., Md.</i>					A. STATE <i>Md.</i> B. COUNTY <i>26-01</i>					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore City</i>					
					D. STREET ADDRESS (If rural, give location) <i>5420 Bucknell Rd.</i>					
5. SEX <i>Male</i>		6. RACE <i>Caucasian</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>		8. DATE OF BIRTH <i>1-3-01</i>		9. AGE (In years last birthday) <i>64</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>meter reader</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Gas & Elec. Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>			
13. FATHER'S NAME <i>Conrad Darmsteadt</i>					14. MOTHER'S MAIDEN NAME <i>Anna Boehner</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>					16. SOCIAL SECURITY NO. <i>212-05-4848</i>		17. INFORMANT <i>Mrs. Bernard Darmsteadt</i>			
					ADDRESS <i>Same</i>					
18. <i>525X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
					(A) <i>Cor pulmonale</i> DUE TO					<i>long standing</i>
					(B) <i>Pulmonary fibrosis & emphysema</i> DUE TO					<i>long standing</i>
					(C)					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										
II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					<i>Secondary Polycythemia</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>7-26-65</i> 19 <i>65</i> to <i>8-2</i> 19 <i>65</i> , that (I) (we) lost saw the deceased alive on <i>8-2</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <i>Mary Tim Ratner</i> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>8-2-65</i>		
23C. PHYSICIAN'S NAME (Type) <i>Mary Tim Ratner</i> M.D.					23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>8/6/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>HOLY REDEEMER CEMETERY</i>			24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 3 1965</i>			25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>			25C. FUNERAL DIRECTOR <i>LEONARD J. RUCK, INC., BALTO., MD. 21214</i>				



BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. **65 8036** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **65 8036**

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)**Jeanette
BARBARA ^ RENNIE**

2. DATE AND HOUR PRONOUNCED DEAD

8-1-65**5:00 P. M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL - DOA4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY**Maryland**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1543 North Gate Road

5. SEX

Female

6. RACE

White7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)**Single**

8. DATE OF BIRTH

Dec. 1, 19469. AGE (In years
last birthday)**18**If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)**Clerk**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

James V. Rennie

14. MOTHER'S MAIDEN NAME

Anna Lenora Lucas15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)**No**16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. James V. Rennie 1543 Northgate Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) **Hemoperitoneum and hemothorax, right**
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO(C)
DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Par. Autopsy20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?**Yes**21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)**Road**

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

**Belair Road - 986 Ft. North
of Perry Hall Road**21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8 1 '65 P. m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒21F. HOW DID INJURY OCCUR?
**Skidded on wet road
Driver in auto-auto collision**

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)**PETER W. RIECKERT, M.D.**

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

8-2-6523A. BURIAL CREMATION,
REMOVAL (Specify)**Burial**

23B. DATE

8/6/1965

23C. NAME of CEMETERY or CREMATORY

Baltimore Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 3 1965

24B. NAME OF REGISTRAR

Robert E. Farkas, M.D.

24C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. 5305 Harford Rd.

ADDRESS

WALLEY FRIDGE

RECORDS

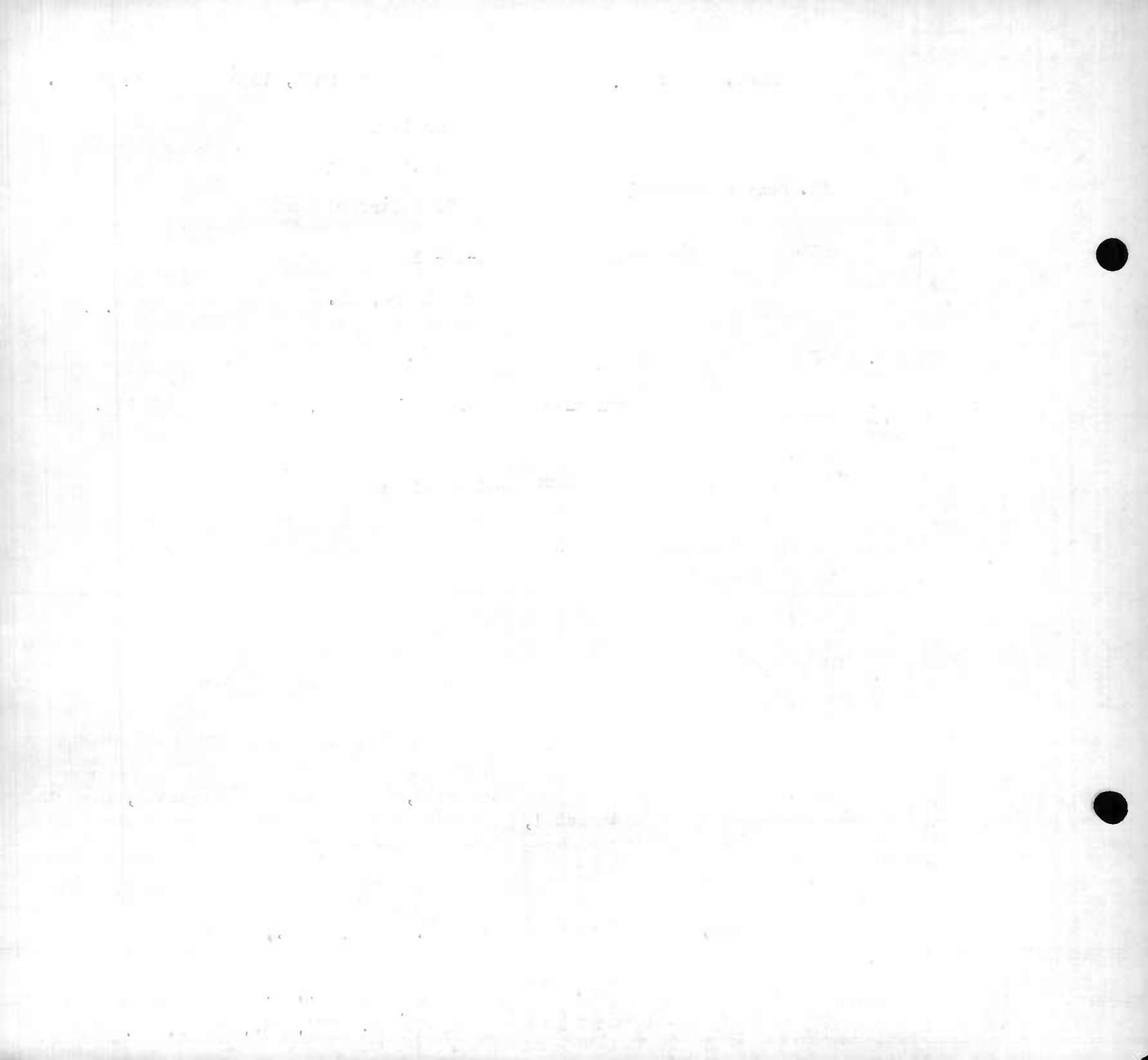
1954



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

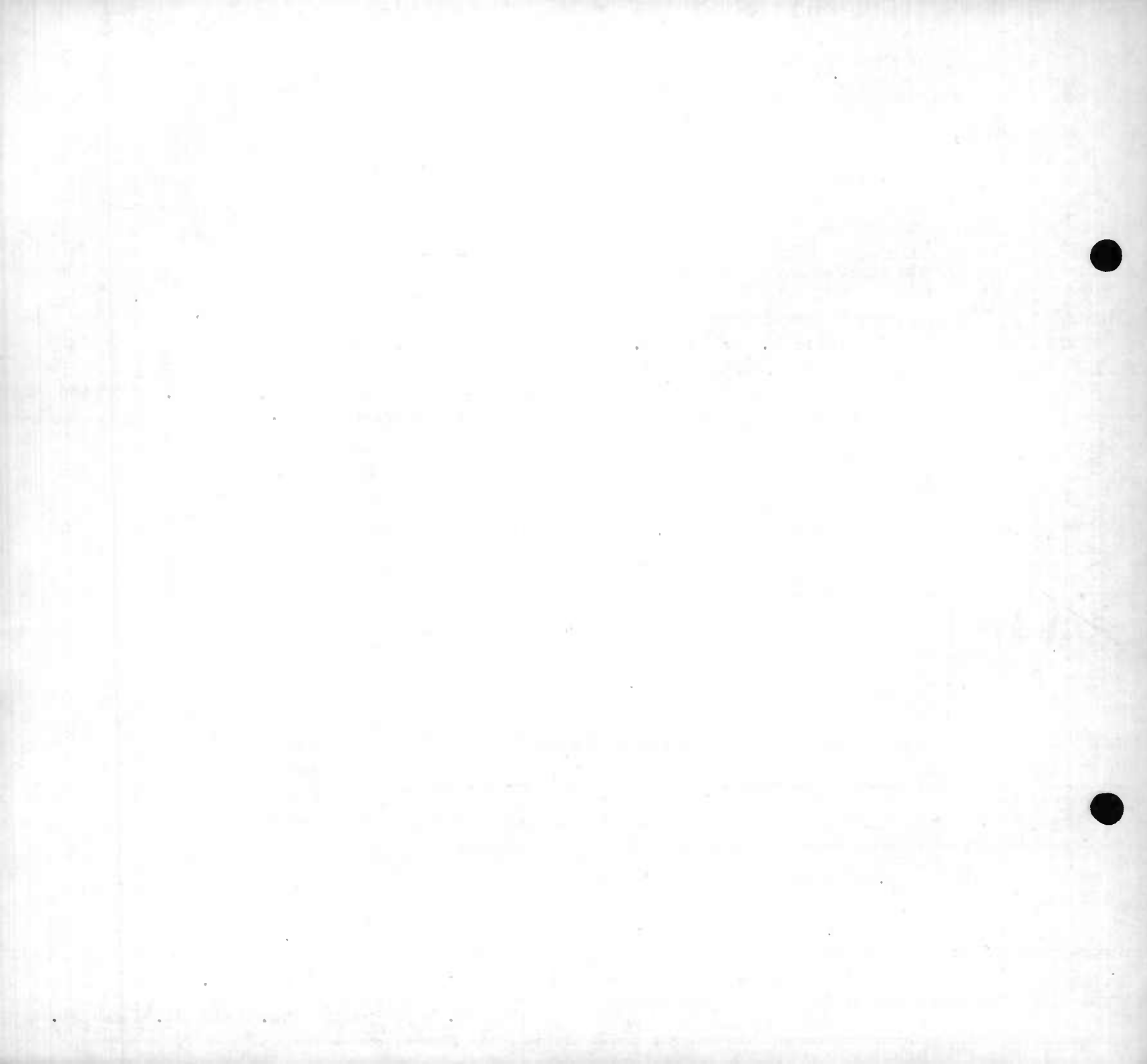
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 65 8037 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="display: flex; justify-content: space-between;"> CERTIFICATE OF DEATH Registered No. 65 8037 </div>			
1. NAME OF DECEASED (Type or Print) Root, Jesse E.		2. DATE AND HOUR OF DEATH August 1, 1965 4:10 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 908 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #18 D. STREET ADDRESS (If rural, give location) 2300 Harford Road	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 6-15-21
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 43
13. FATHER'S NAME JESSE E. ROOT		12. CITIZEN OF WHAT COUNTRY? U.S.A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-12-8378	17. INFORMANT MRS. WILLIAM PETR, 4913 HAZELWOOD AVE.
18. 10X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Mitral stenosis with congestive cardiac failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from August 1, 19 65 to August 1, 19 65 , that (I) (we) last saw the deceased alive on August 1, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Govinda Rao</i> 23C. PHYSICIAN'S NAME (Type) Govinda Rao,			23B. DATE SIGNED August 2, 1965
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/5/65	24C. NAME of CEMETERY or CREMATORY GARDENS OF FAITH CEMETERY
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC., BALTO., MD. 21214
24D. LOCATION (City, town, or county) (State) BALTO., MD.		24E. ADDRESS 1400 N. Caroline St., 21213	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

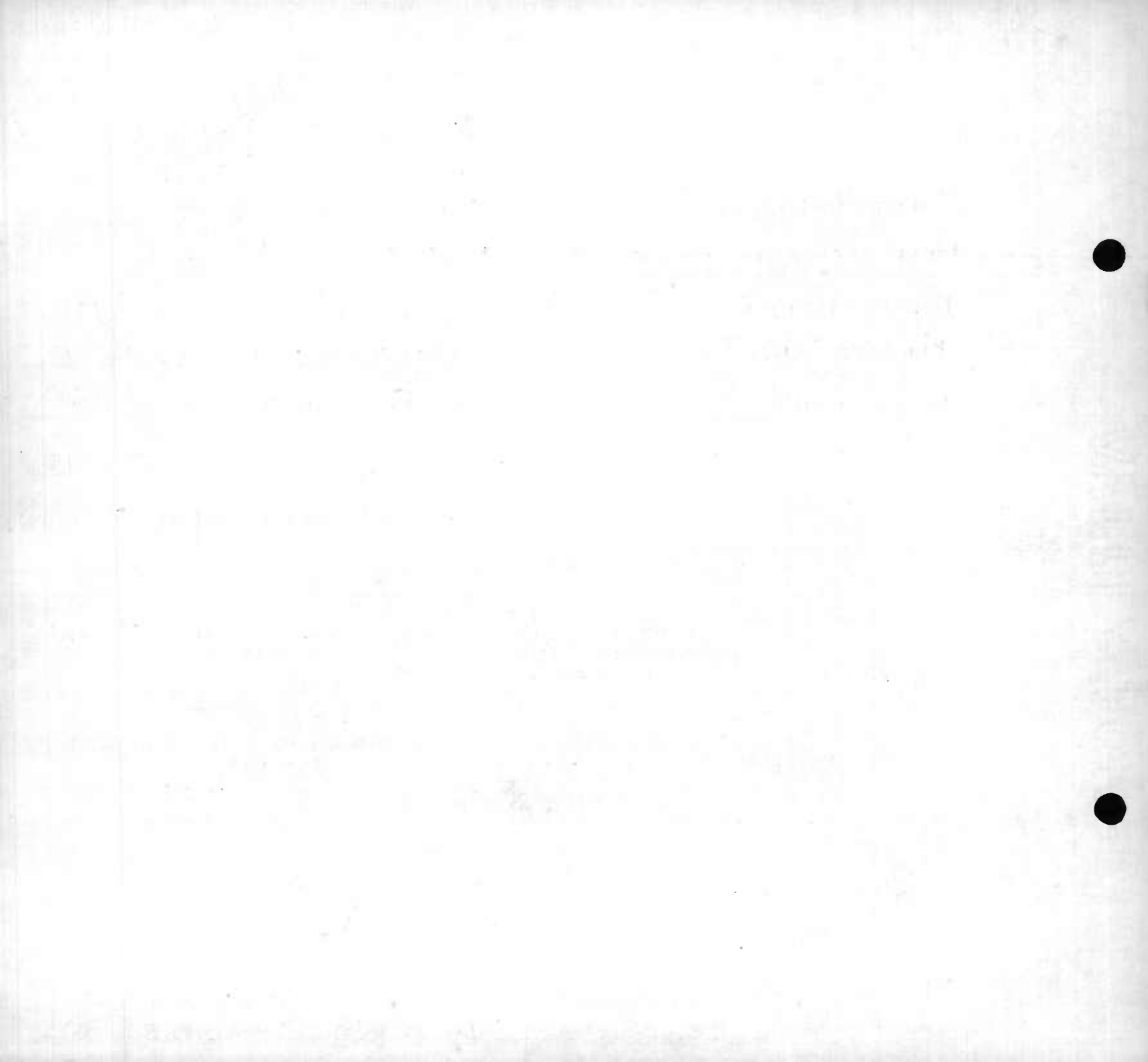
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 8038	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				PAUL COLLEY		7-27-65 5¹⁵ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital				A. STATE Maryland			
				B. COUNTY 4-01			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) Unknown 514 E. PRATT ST.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single		8. DATE OF BIRTH 4-11-22	9. AGE (In years last birthday) 43	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lawrence W. Colley Sr.				14. MOTHER'S MAIDEN NAME Leona McDaniels			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 223-14-5770		17. INFORMANT ADDRESS Arritt Funeral Home. 1102 S. Highland Ave Covington Va.			
18. 322121 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Pancreatitis & shock DUE TO (B) Alcoholism DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH several hours many years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Gastritis & aneurysm							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes) or No YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>(this hospital)</u> attended the deceased from July 26, 19 65 to July 27, 19 65 , that (I) <u>(we)</u> last saw the deceased alive on July 27, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.							
23A. SIGNATURE Patrick F. Dougherty, Jr. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED 7/28/65	
23C. PHYSICIAN'S NAME (Type) PATRICK F. DOUGHERTY, JR. M.D.				23D. ADDRESS Mercy Hospital, Balt. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 7-28-65		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Covington Va.	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Wm. Cook Brooks Inc. 1217 St. Paul St.		ADDRESS =	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

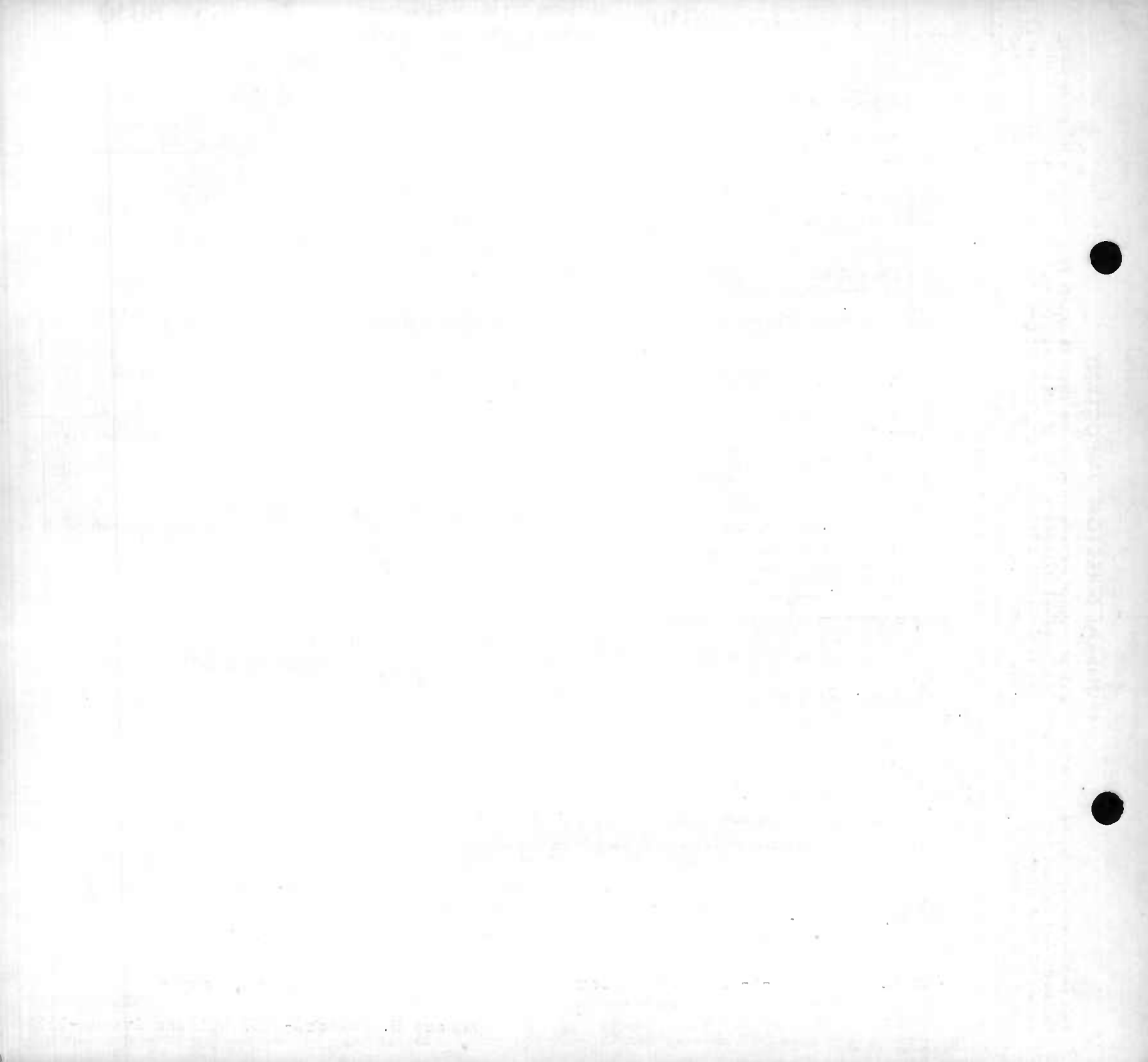
BIRTH NO. 65 8039				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8039	
M.E. CASE NO. 65 8039				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CLARENCE ANTOINE BENNETT				2. DATE AND HOUR OF DEATH JULY 29, 1965 8 ¹⁰ P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL of BALTIMORE, INC.		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY BALTIMORE CITY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY # 21234			
				D. STREET ADDRESS (If rural, give location) 7617 DANIEL AVENUE 21-05			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12-24-98	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TROLLEY OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY BALTIMORE TRANSIT CO.		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HOWARD JOHN BENNETT				14. MOTHER'S MAIDEN NAME WHITBECKER ANNIE E			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) U.S. NAVY WWI		16. SOCIAL SECURITY NO. 213-10-1054		17. INFORMANT PEARL KATHERINE BENNETT		ADDRESS 7617 DANIEL AVE	
18. 201X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) LEUKOENCEPHALOPATHY (A) DUE TO DISSEMINATED HODGKIN'S DISEASE 2 YEARS (B) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (C)				INTERVAL BETWEEN ONSET AND DEATH 13 DAYS			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. OLD CVA CONGESTIVE HEART FAILURE 4 YEARS							
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NONE			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) NONE		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? NONE			
22. I certify that (I) (this hospital) attended the deceased from 7/1 1965 to 7/29 1965, that (I) (we) last saw the deceased alive on 7/29 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph S. Weinstock M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/29/65	
23C. PHYSICIAN'S NAME (Type) Joseph S. Weinstock				23D. ADDRESS SINAI HOSP. of BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-2-1965		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Co. Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Joseph S. Weinstock		ADDRESS 7401 Balaban Road (36)	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

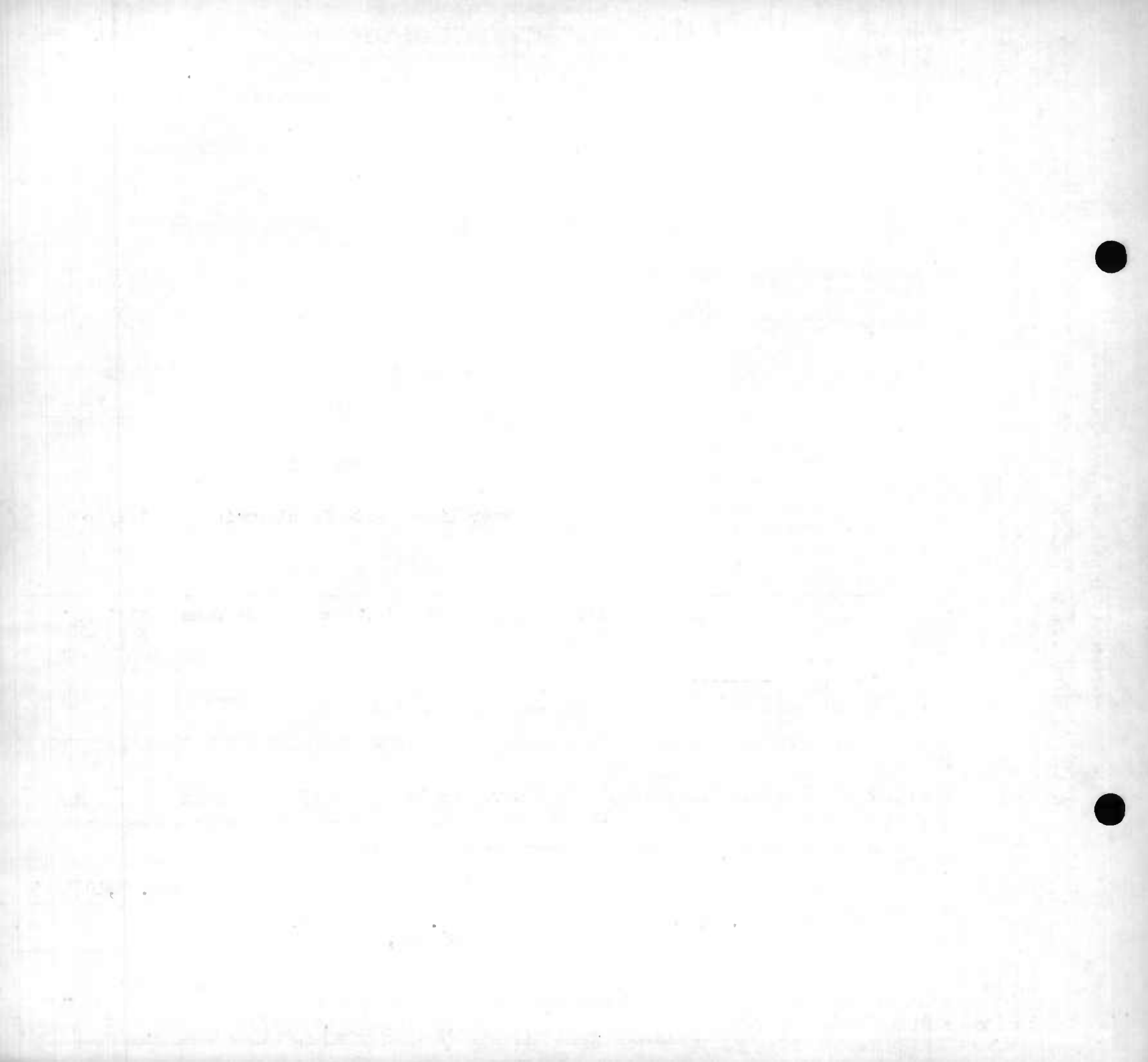
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 8040		CERTIFICATE OF DEATH		65 8040	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Louise Frances Gloyd</i>			2. DATE AND HOUR OF DEATH <i>7/30/65 1:25 A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Ad.</i> B. COUNTY <i>25-41</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 29</i> D. STREET ADDRESS (If rural, give location) <i>1119 Haverhill Rd.</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>5/28/74</i>	9. AGE (In years last birthday) <i>91</i>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Wisconsin</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Andrew Kern</i>		14. MOTHER'S MAIDEN NAME <i>Lena Grosser</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>Lester Edmunds</i> ADDRESS <i>1034 Rockhill Rd. Balt.</i>	
18. <i>422.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Cellulitis, (D) leg</i> <i>Arteriosclerotic Cardiovascular disease</i>			CAUSE OF DEATH (A) DUE TO (B) DUE TO <i>unknown</i>		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Chronic Venous Insufficiency (D) leg.</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>		
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7/27</i> 19 <i>65</i> to <i>7/30</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>7/29</i> 19 <i>65</i> and that in (my) (four) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Bernard du Buy</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>7/30/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. Bernard du Buy</i>		23D. ADDRESS <i>University Hosp.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>8-2-65</i>	24C. NAME OF CEMETERY or CREMATORY <i>Loudon Park</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 3 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Howard H. Hubbard</i> ADDRESS <i>4107 Wilkens Avenue-21229</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

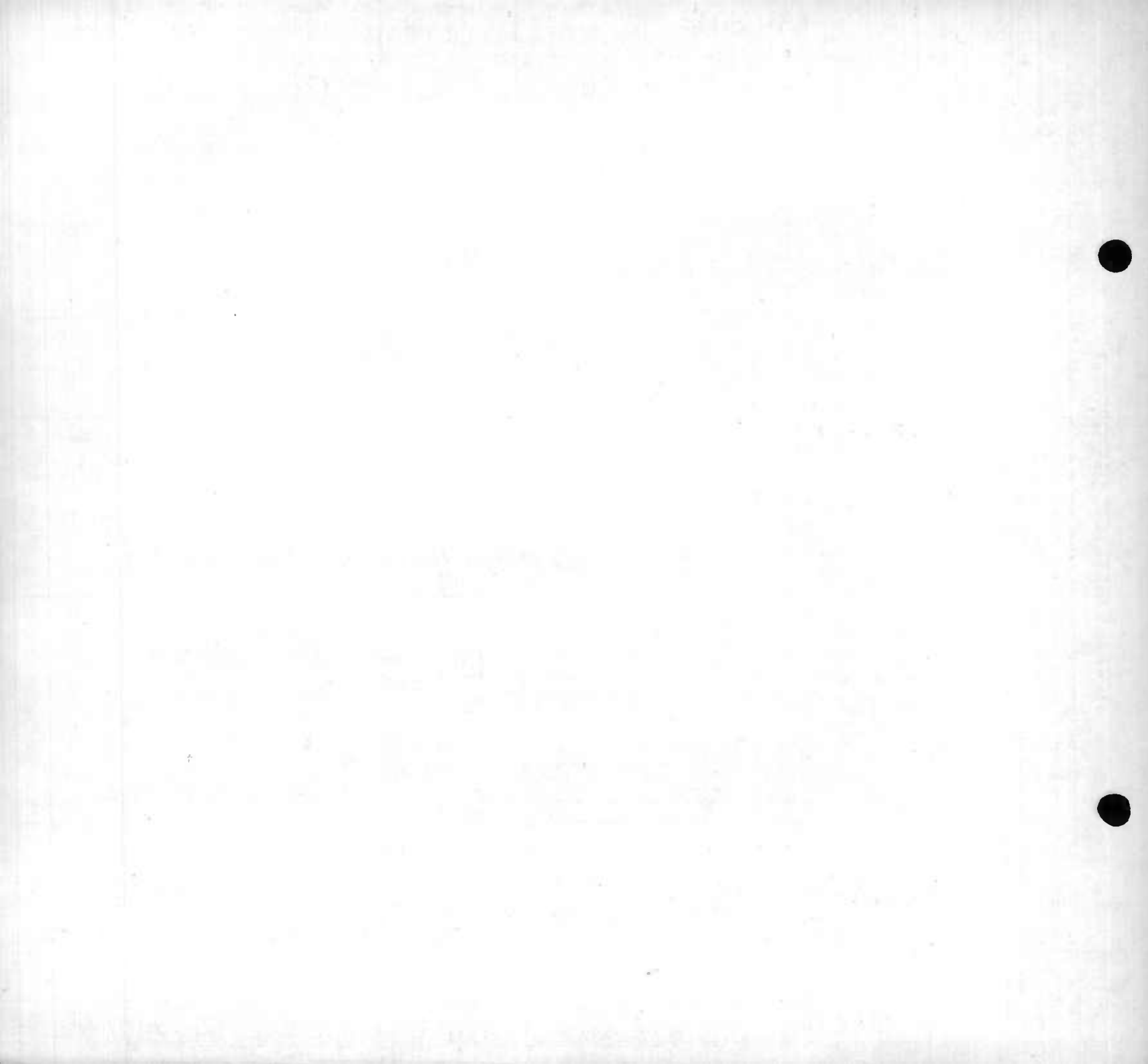
BIRTH NO. 65 8041				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8041	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Philip MAHEK		2. DATE AND HOUR OF DEATH Aug. 2, 1965 2:15 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE Md		B. COUNTY HOS	
2917 E. BALTIMORE ST.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
D. STREET ADDRESS (If rural, give location)				330 S. PATTERSON PARK AVE			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH MAY-10-1895	9. AGE (In years last birthday) 70	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DESIGNER		10B. KIND OF BUSINESS OR INDUSTRY CLOTHING		11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT MR. Emil MAHEK 2606 E. BALTIMORE ST.	
18. 42011 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CORONARY THROMBOSIS				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 8/2/65	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO Generalized Arteriosclerosis		1/2/56	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Post Herpetic Neuralgia, left side of face Anemia		11/16/63 6/29/65	
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -----		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from November 16 1963 to August 2 1965, that (I) (we) last saw the deceased alive on July 26 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph F. Drenga, M.D.				23B. DATE SIGNED Aug. 3, 1965			
23C. PHYSICIAN'S NAME (Type) Joseph F. Drenga				23D. ADDRESS 209 S. Chester Str. Baltimore, Md 21231			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-5-65		24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cem.		24D. LOCATION (City, town, or county) (State) BALTIMORE Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1965		25B. NAME OF REGISTRAR Robert E. Davis		25C. FUNERAL DIRECTOR B. Polyzoussi		ADDRESS 2818 E. BALTIMORE ST.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

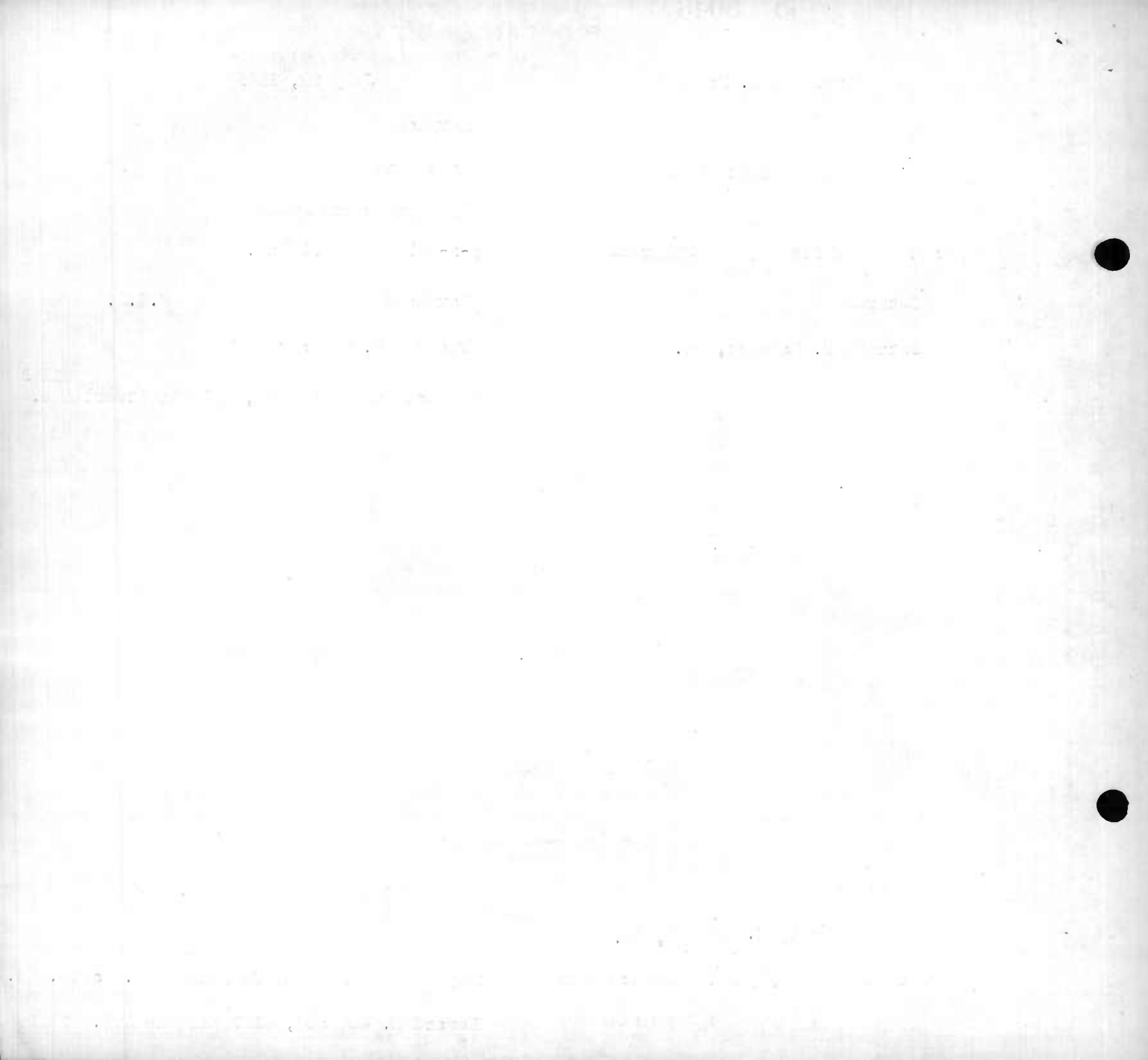
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8042	
BIRTH NO. 65 8042		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or print) JACKSON, JOSEPH JR.		2. DATE AND HOUR OF DEATH AUGUST 1, 1965 3:15AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 25-32			
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL ASHBURTON ST.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 3040 SEAMAN AVE.			
5. SEX MALE	6. RACE COLORED	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH JUNE 1, 1906	9. AGE (In years lost birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY social security		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME JOSEPH A. JACKSON SR.		14. MOTHER'S MAIDEN NAME MARY CHASE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 213-05-4139		17. INFORMANT Florence Jackson	
18. 260X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Lysis of Myocardial Tissues, Left Tan- port, late. Bronchopneumonia (B) CVA - Thrombosis (C) DIABETIC MELLITUS, HYPERTENSION RENAL STONE		INTERVAL BETWEEN ONSET AND DEATH 4 days 10 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 7-19-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JULY 18 1965 to AUGUST 1 1965 , that (I) (we) last saw the deceased alive on AUGUST 1 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Abraham A. Constantino Jr. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED AUGUST 1, 1965	
23C. PHYSICIAN'S NAME (Type) DR. W. BIRT		ADDRESS LUTHERAN HOSPITAL OF MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/5/65		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) (State) Baltimore Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1965		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Washington S. Phillips	
				ADDRESS 1727 N. Monro	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				Registered No.			
65 8043				65 8043				65 8043			
M.E. CASE NO.				1. NAME OF DECEASED				2. DATE AND HOUR OF DEATH			
(Type or Print)				Lawrence A. Hackett				July 29, 1965			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				M.			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY							
1910 Breitwert Avenue				Maryland				25-43			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)							
				D. STREET ADDRESS (If rural, give location)							
1910 Breitwert Avenue											
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
Male		White		Divorced		9-5-07		57 Yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Retired								Maryland			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
U.S.A.				Patrick F. Hackett, Sr.				Frances V. Michaels			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
No								Miss Catherine Hackett, 1910 Breitwert Ave. 21230			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES				(A) DUE TO							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO							
				(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
03/15/65		Biopsy of Throat		NO							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from July 19 1965 to July 29 1965, that (I) (we) last saw the deceased alive on July 28 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
Harry T. Wilson, Jr.				8/1/65							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
				6011 York Rd.							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
Burial		8/2/1965		New Cathedral Cemetery		4300 Old Frederick Rd. Balto. Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
AUG 3 1965		Robert E. Taylor		Howard H. Hubbard		4107 Wilkens Ave. 21229					



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8044

BALTIMORE CITY HEALTH DEPARTMENT

65

8044

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN IRVING JACKSON

2. DATE AND HOUR PRONOUNCED DEAD

July 25, 1965

12:15 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2210 Eutaw Place

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-25-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

AUG 3 1965

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 3 1965

Rudiger Breitenecker

MORTUARY SERVICE - BCHD

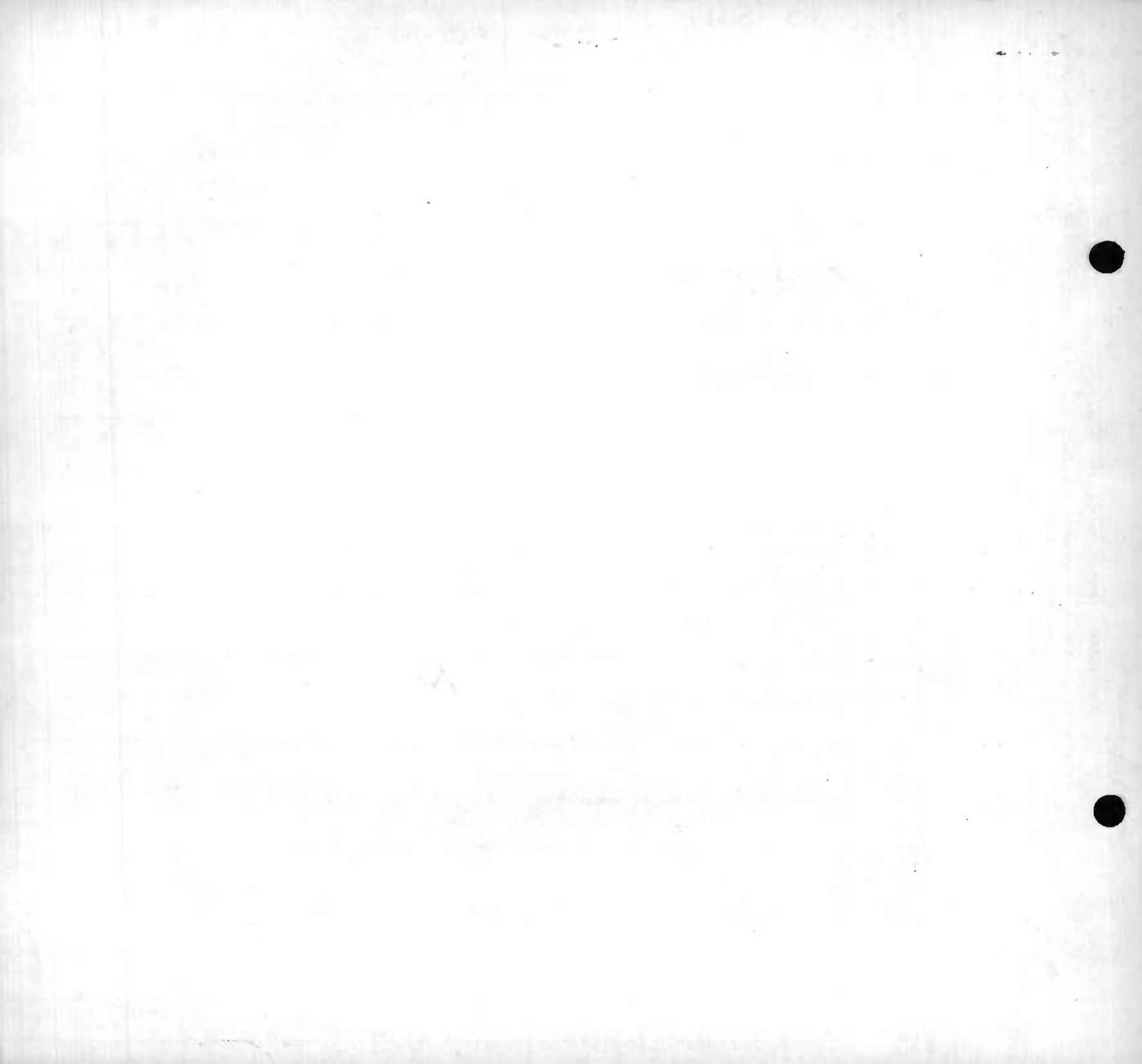
WATKINS FORGE

THE COMPANY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

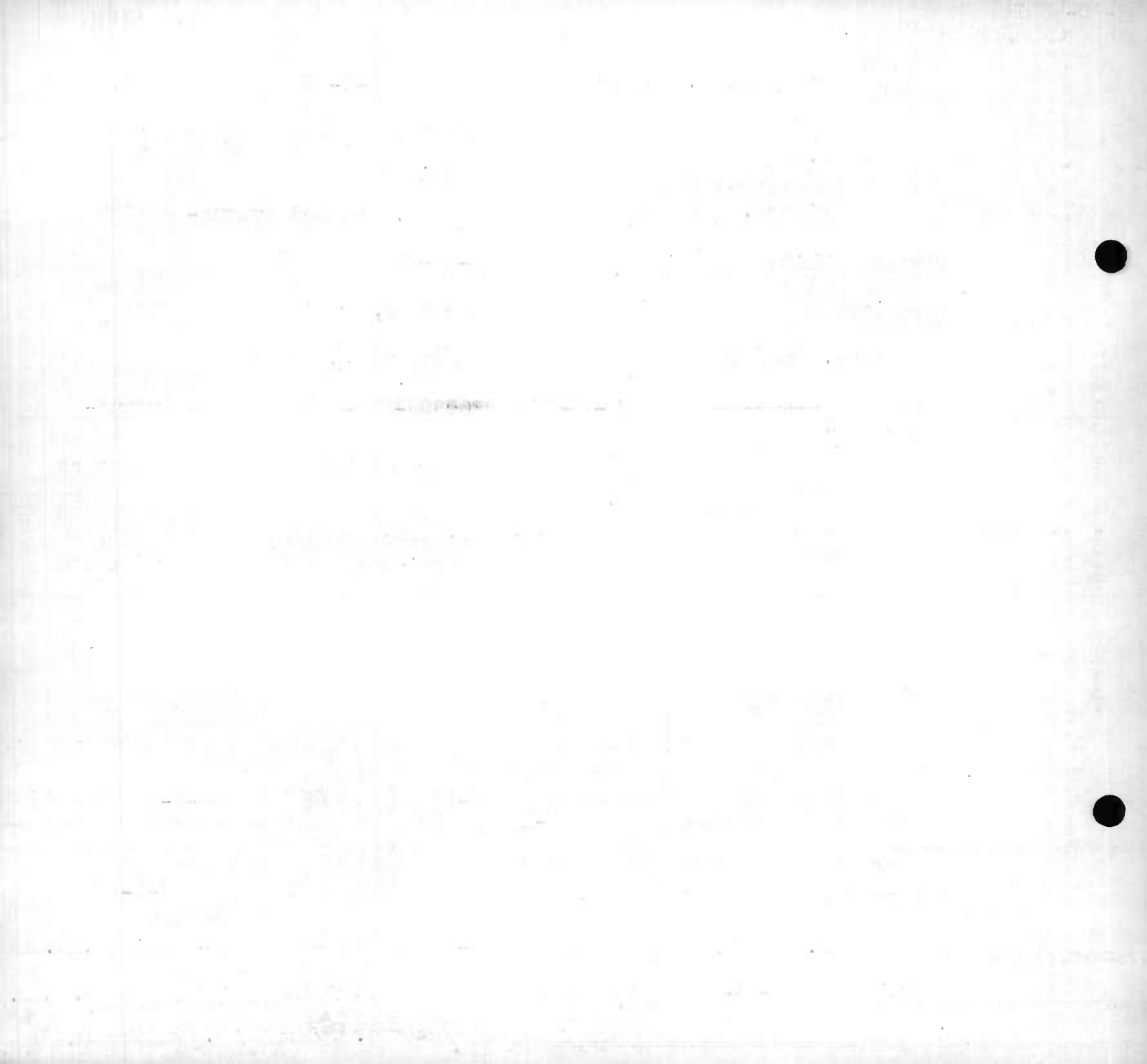
BIRTH NO. 65-1914965 8045				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8045	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CRYSTAL M. RIDDICK				2. DATE AND HOUR OF DEATH JULY 29, 1965 15:05 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSP. OF MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-48 D. STREET ADDRESS (If rural, give location) 2206 ELSINOR AVE. BALTO. MD			
5. SEX F	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) INFANT	8. DATE OF BIRTH 7/26/65	9. AGE (In years last birthday) 2	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO. MARYLAND		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME AVALON REDDICK 2206 ELSINOR AVE. BALTO. MD.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. 760.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) probable intracranial injury DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JULY 27 1965 to JULY 29 1965, that (I) (we) last saw the deceased alive on JULY 28 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Marcia Evangelista M.D.				23B. DATE SIGNED 7/29/65		23C. PHYSICIAN'S NAME (Type) MARCIA EVANGELISTA M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-30-65		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1965		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR C. Wainwright		ADDRESS 2700 Edmondson Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

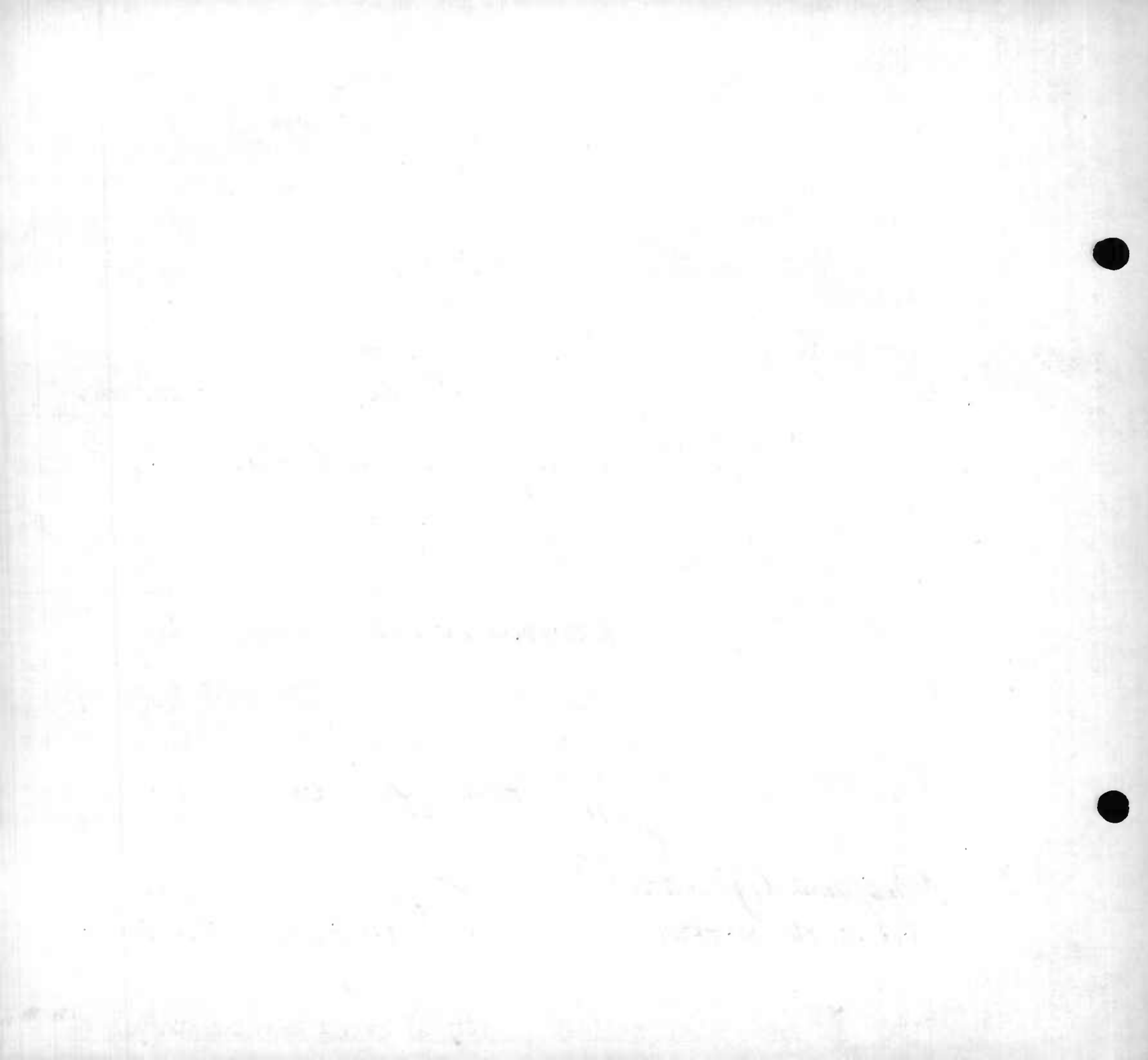
BIRTH NO. 65 8046		BALTIMORE CITY HEALTH DEPT.		Registered No. 65 8046	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Anna Hoyt (Anna D. Hoyt)			2. DATE AND HOUR OF DEATH 8-1-65 7:20 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224			A. STATE Maryland B. COUNTY H04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1120 S. Kenwood Avenue- #21224		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 9-10-02	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY House Work		11. BIRTHPLACE (State or foreign country) Maryland, Baltimore	
13. FATHER'S NAME George P. Krollman			14. MOTHER'S MAIDEN NAME Elizabeth Emkey		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-28-5633		17. INFORMANT #21224 ADDRESS RECORDS-BCH-4940 Eastern Avenue-	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolus			INTERVAL BETWEEN ONSET AND DEATH 6 hours		
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Disseminated Squamous Cell Carcinoma			6 months		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-13 1965 to 8-1 1965, that (I) (we) last saw the deceased alive on 8-1 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stephen Gregg				23B. DATE SIGNED 8-1-65	
23C. PHYSICIAN'S NAME (Type) Dr. Stephen Gregg				23D. ADDRESS #21224 BCH-4940 Eastern Avenue-Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-5-65		24C. NAME of CEMETERY or CREMATORY Sacred Heart Cemetery	
24D. LOCATION 7401 German Hill Road Balto., Md.		24E. DATE REC'D BY HEALTH DEPT. AUG 4 1965			
24F. NAME OF REGISTRAR Robert E. Taylor		24G. FUNERAL DIRECTOR Charles S. Zeiler 901 S. Conkling St. #24			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8047		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8047	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) CORA BELLE EWING			2 August, 1965 7:00 PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gould Convelescarium			A. STATE Md. B. COUNTY Baltimore		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dundalk		
			D. STREET ADDRESS (If rural, give location) 13 Broadship		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 9 July, 1887	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Hewett			14. MOTHER'S MAIDEN NAME Cora B. Cochran		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Vernon Hackett, 3018 Overland Rd. 21214		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 422.14-153.8 ARTERIOSCLEROTIC C.V.D's. DUE TO			INTERVAL BETWEEN ONSET AND DEATH 3 yrs.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			(B) DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			NUTRITION OF LARGE INTERESTING 6 mos		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from FEB. 4 1963 to 8/2 1965, that (I) (we) last saw the deceased alive on 8/1 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Benjamin Hylton			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/3/65
23C. PHYSICIAN'S NAME (Type) DR. B. HILTON			23D. ADDRESS 121 S. HIGHLAND AVE BALTIMORE		
24A. BURIAL CREMATION, REMOVAL (Specify) burial	24B. DATE 8-5-65	24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore County, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Ulrich Funeral Home, Dundalk, Md.	



non-med. DR. HAUSER - MEDICAL EXAMINER
FUNERAL DIRECTOR: IMPORTANT
CHVNH30 VJH3313
81 6 11 65

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death is shown as: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 326 65 8048		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 85 8048	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Getscher, Bernard</i> Bernard J. Getscher		2. DATE AND HOUR OF DEATH <i>8/1/65 @ 6:30 pm</i> 8/1/65 6:30 PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i>		A. STATE B. COUNTY <i>MARYLAND Baltimore</i> 53-00			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore, Maryland</i>		D. STREET ADDRESS (If rural, give location) <i>6519 Golden Ring Rd.</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>11/7/12</i>	9. AGE (In years last birthday) <i>52 53</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <i>CONRAD Getscher</i>		14. MOTHER'S MAIDEN NAME <i>LOUISE BEHR</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>216-09-9926</i>		17. INFORMANT <i>Family</i> ADDRESS <i>6519 Golden Ring Road</i>	
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO <i>Arteriosclerotic coronary artery disease</i> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>yrs. ?</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) this hospital attended the deceased from <i>8/1 1965</i> to <i>8/1 1965</i> , that (1) we lost saw the deceased alive at <i>6:25 pm 8/1 1965</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) We (did) (did not) view the body after death.					
23A. SIGNATURE <i>Barry J. Zacherle</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8/1/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Barry J. Zacherle</i>		23D. ADDRESS <i>550 N. Broadway, Baltimore, Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/4/65</i>		24C. NAME of CEMETERY or CREMATORY <i>Angel Hill</i>	
24D. LOCATION (City, town, or county) (State) <i>Havre de Grace-Harford Co., Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 4 1965</i>			
25B. NAME OF REGISTRAR <i>Philip E. Gvach</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Rosedale Funeral Home Philip E. Gvach-1211 Chesaco Ave.-21206</i>			

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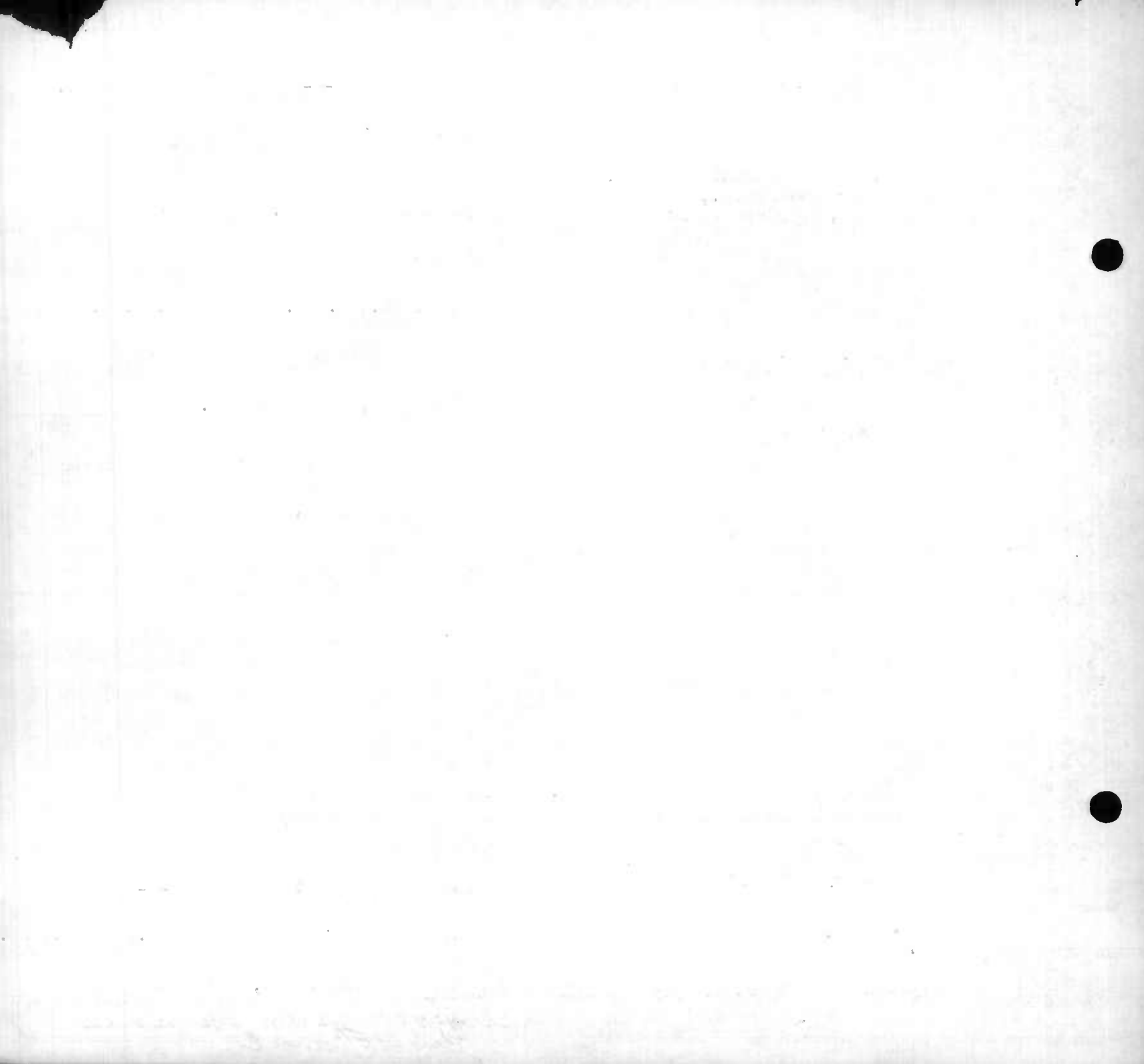
CONFIDENTIAL

CONFIDENTIAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8049				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8049	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HARDEN, CHARLES THOMAS				2. DATE AND HOUR OF DEATH 8-2-65 9:32 a. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Blvd., Baltimore, Maryland 21218				A. STATE MARYLAND B. COUNTY 12-03			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 316 ILLCHESTER AVE. Ilchester			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11/21/16	9. AGE (In years last birthday) 48	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAB DRIVER			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BERKLEY CO., W. VA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME JAMES T. HARDEN				14. MOTHER'S MAIDEN NAME CORA MAE FELLERS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 6/14/40 to 9/29/43		16. SOCIAL SECURITY NO. 236 14 7920		17. INFORMANT ADDRESS VA Hospital, Baltimore, Md. 21218			
18. 490X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ASPIRATION DUE TO PNEUMONIA, RIGHT UPPER LOBE DUE TO				INTERVAL BETWEEN ONSET AND DEATH 30 minutes 10 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC OBSTRUCTIVE PULMONARY EMPHYSEMA				10 years			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 10		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (y) (this hospital) attended the deceased from July 23 19 65 to August 2 19 65 , that (y) (we) last saw the deceased alive on August 2 19 65 and that in (y) (our) opinion death occurred on the date and hour and from the causes stated above. (y) (We) (did) (did not) view the body after death.							
23A. SIGNATURE  M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED 8-2-65	
23C. PHYSICIAN'S NAME (Type) ROBERT W. HAMILTON				23D. ADDRESS M.D. VA Hospital, 3900 Loch Raven Blvd., Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE August 5, 1965		24C. NAME of CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Burgee Funeral Home		ADDRESS 3631 Falls Road	



BIRTH NO.

65 8050

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM B. TAYLOE

2. DATE AND HOUR PRONOUNCED DEAD

July 31, 1965 9:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Virginia

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Middleburg R.F.D.

D. STREET ADDRESS (If rural, give location)

5. SEX

Male

6. RACE

Caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

March 5, 1949

9. AGE (In years
last birthday)

16

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William Tayloe

14. MOTHER'S MAIDEN NAME

Janet Roszel

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. (If yes, give war or dates of service))

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

Mr. R.J. Roszel 1415 Bolton St.

18.

E919.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot Wound of Lower Neck.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

House

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

1508 Bolton Street

21D. TIME
OF INJURY
(APPROX.)

(Month)

(Day)

(Year)

(Hour)

(Min.)

7

31

'65

P

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Boys examining rifle which was
accidentally fired.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/1/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-2-65

23C. NAME OF CEMETERY or CREMATORY

Loudon Park

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 4 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

John O. Mitchell & Sons-Wiedefeld

ADDRESS

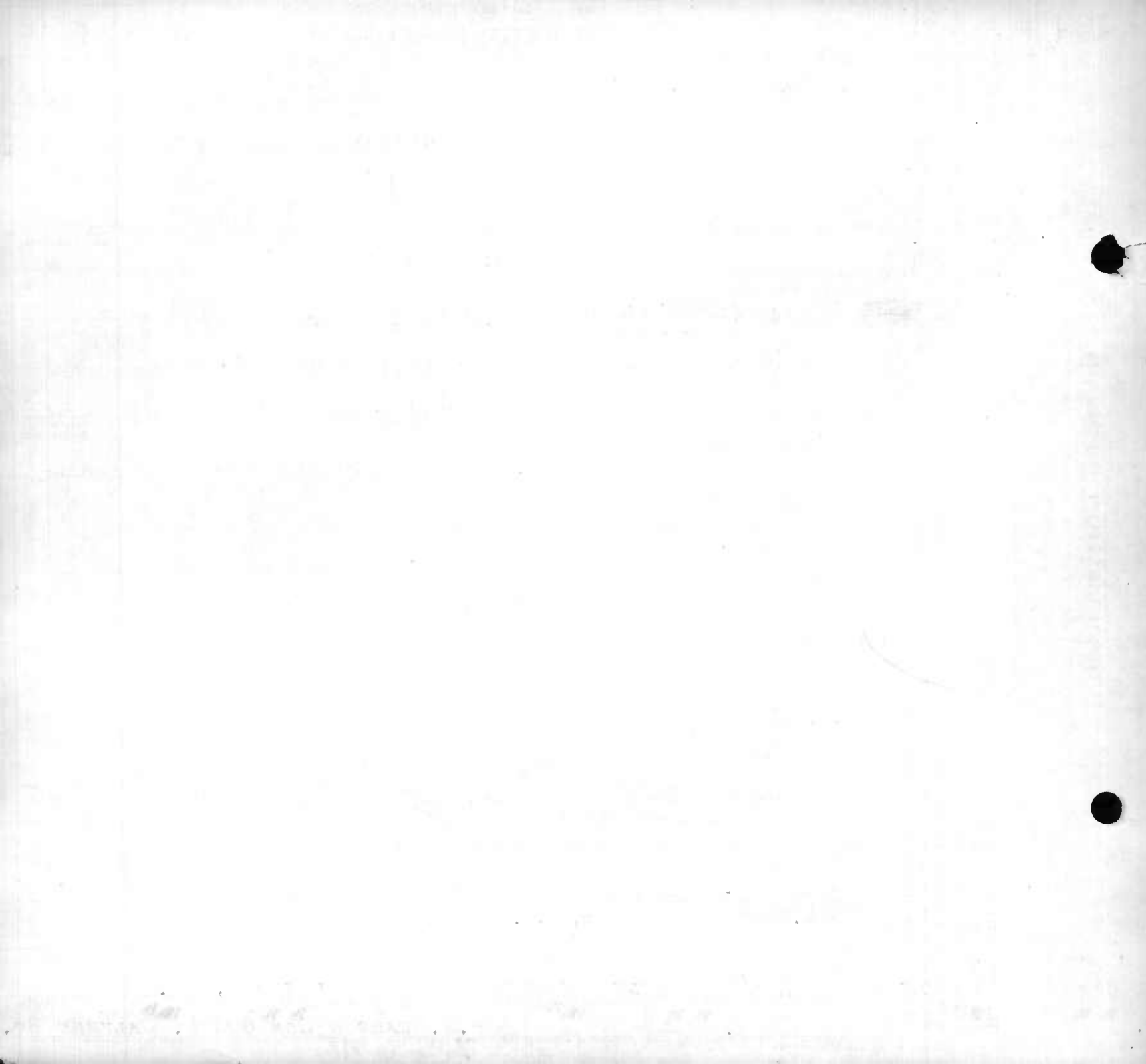
6500 York Road Baltimore, Md.

WALTER H. HINGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8051	
BIRTH NO. 65 8051		CERTIFICATE OF DEATH			
M.E. CASE NO. 65 8051		1. NAME OF DECEASED (Type or Print) Nast Vogel, Lawrence		2. DATE AND HOUR OF DEATH 8-1-65 1 55 3P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 91 Keswick		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 13-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 700 W 40th Street			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11-30-1889	9. AGE (In years last birthday) 75 yrs	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Retired - Balto -		10B. KIND OF BUSINESS OR INDUSTRY GAS & ELEC. Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Rudolph Nast Vogel		14. MOTHER'S MAIDEN NAME Margaret Weissner	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-05-2673		17. INFORMANT Grace S. McFarland ADDRESS 700 W 40th St.	
18. 527.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) Pulmonary Emphysema		(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 25 19 63 to August 1 19 65 , that (I) (we) last saw the deceased alive on July 31 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. Grafton Hersperger M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED August 2, 1965	
23C. PHYSICIAN'S NAME (Type) W. Grafton Hersperger, M.D.				23D. ADDRESS Keswick	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/4/65		24C. NAME of CEMETERY or CREMATORY HOLY REDEEMER	
24D. LOCATION (City, town, or county) BALTIMORE, MD.		24E. STATE (State) MD.			
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1965		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS H.W. MEARS & SON 805 N. CALVERT ST.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 65 8052	
BIRTH NO. 65 8052		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CASIMIR J. MODUSZEWSKI		2. DATE AND HOUR OF DEATH 8-2-65 11:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital		A. STATE Maryland			
		B. COUNTY 1-03			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 502 S. Milton Ave.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5-1-18	9. AGE (In years lost birthday) 47	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10B. KIND OF BUSINESS OR INDUSTRY Kogan Bros		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? Poland		13. FATHER'S NAME Joseph Moduszevski		14. MOTHER'S MAIDEN NAME Mary ? Milosek	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No ?		16. SOCIAL SECURITY NO. 212-05-9249		17. INFORMANT ADDRESS ELEANOR MODUSZEWSKI 302 S. Milton	
18. 237X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH BRAIN TUMOR		INTERVAL BETWEEN ONSET AND DEATH ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 04-5-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Brain Tumor		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 8-2-65 19 65 to 8-3-65 19 65 , that (I) (we) last saw the deceased alive on 8-2-65 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Antonio S.C. Termino		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-3-65	
23C. PHYSICIAN'S NAME (Type) ANTONIO S.C. TERMINO		23D. ADDRESS Church Home & Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-6-1965	24C. NAME of CEMETERY or CREMATORY St. Stanislaus		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901 Eastern Ave.	

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Kodak film

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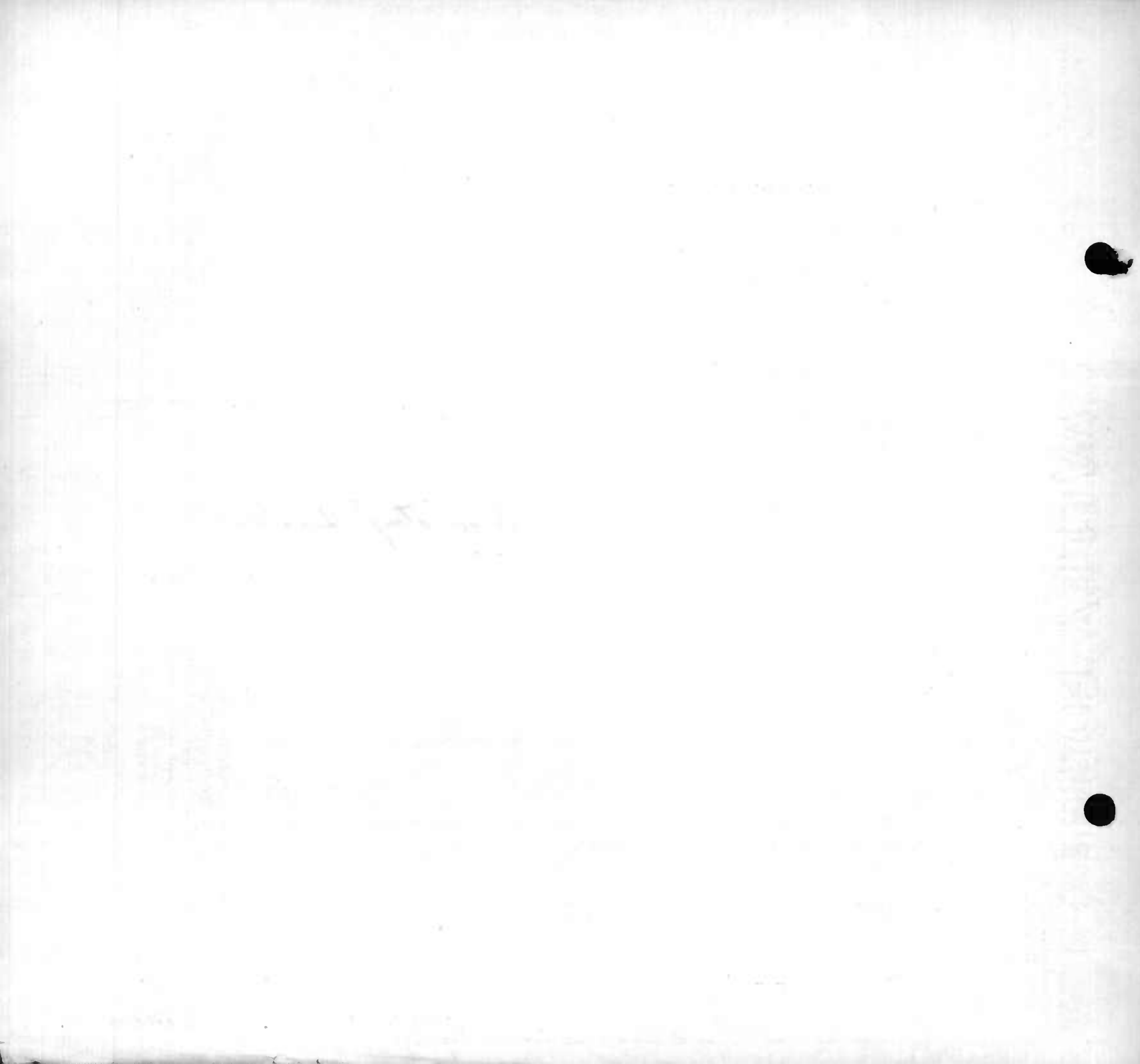
Blank House - 14 Sept

Blank House - 14 Sept

FUNERAL DIRECTOR: IMPORTANT

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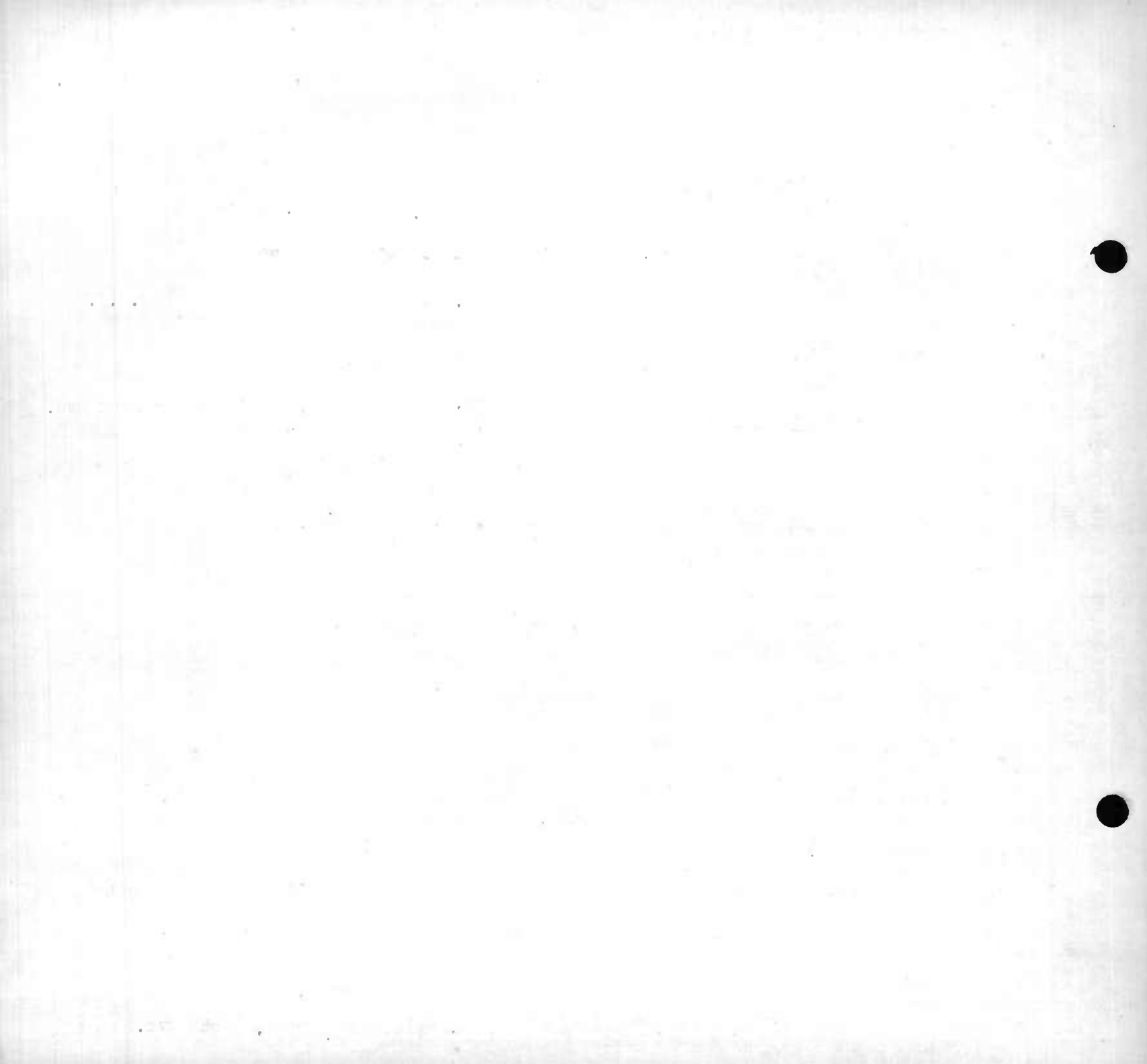
BALTIMORE CITY HEALTH DEPARTMENT				65 80531-43-28	
BIRTH NO. 65-18764 65 8053				REGISTERED NO.	
M.E. CASE NO.				8/2/65 11:00 P.M.	
1. NAME OF DECEASED (Type or Print) <i>Baby Girl Dolan</i>				2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University Hospital</i>				A. STATE <i>Maryland</i> B. COUNTY <i>26-10</i>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>3260 McElderry St, Baltimore</i>	
				D. STREET ADDRESS (If rural, give location) <i>Maryland</i>	
5. SEX <i>Female</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH <i>8-2-65</i>	9. AGE (In years last birthday) <i>13 hrs.</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>University Hospital</i>	
13. FATHER'S NAME <i>Ralph M. Dolan</i>			14. MOTHER'S MAIDEN NAME <i>Sandra Bragg</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>Ralph M. Dolan</i>	
				ADDRESS <i>3200 McElderry Street</i>	
18. <i>773.5 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Immaturity</i>				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Respiratory Distress</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Aug. 2 1965</i> to <i>Aug. 2 1965</i> , that (I) (we) last saw the deceased alive on <i>Aug. 2 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Grace P. Ayckyo</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>GRACE P. AYCKYO</i>				23D. ADDRESS <i>University Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-4-1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>Glen Haven</i>	
				24D. LOCATION (City, town, or county) (State) <i>Glen Burnie, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 4 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Tarkenton</i>		25C. FUNERAL DIRECTOR <i>Lilly & Zeiler Inc.</i>	
				ADDRESS <i>1901 Eastern Ave.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8054	
BIRTH NO. 65 8054		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Corrine Smith		2. DATE AND HOUR OF DEATH August 2, 1965 1:25 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1-8-3		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland		D. STREET ADDRESS (If rural, give location) 513 N. Patterson Park Avenue			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 6-15-1895	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Andrew Gillispi		14. MOTHER'S MAIDEN NAME Ann Herrington	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Maude Lovely 513 Patterson Park Ave.	
18. 153.8 + 260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Intestinal Obstruction		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from July 26, 1965 to August 2, 1965 , that (I) (we) last saw the deceased alive on August 2, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Alvin Thompson		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 3, 1965	
23C. PHYSICIAN'S NAME (Type) Alvin Thompson		23D. ADDRESS 1514 Division Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/65		24C. NAME of CEMETERY or CREMATORY Cheraw, South Carolina	
24D. LOCATION (City, town, or county) (State) Cheraw, South Carolina		25A. DATE REC'D BY HEALTH DEPT. AUG 4 1965		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR Halstead		ADDRESS 1206 W. North Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8055	
BIRTH NO. M.E. CASE NO.		65 8055		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Branch, William			August 2, 1965 10 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE Maryland		
St. Joseph Hospital			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21218		
			D. STREET ADDRESS (If rural, give location) 2119 Barkley St. Barclay		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH March 23, 1915	9. AGE (In years lost birthday) 50	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Gus Lee Branch			14. MOTHER'S MAIDEN NAME Isabelle		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-01-3407		17. INFORMANT Mrs. Isabelle McDonald	
				ADDRESS 748 W. North Ave.	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Massive cerebral hemorrhage DUE TO (B) DUE TO (C) DUE TO		
INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 1, 1965 to August 2, 1965 , that (I) (we) last saw the deceased alive on August 2, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  M.D.				23B. DATE SIGNED August 2, 1965	
23C. PHYSICIAN'S NAME (Type) Govinda Rao,				23D. ADDRESS 1400 N. Caroline St., Baltimore, Maryland 21213	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/5/65		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery	
				24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1965		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR A. Halstead	
				ADDRESS 1206 W. North Ave.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 8056	
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)		65 8056 PARKER EDNA		2. DATE AND HOUR OF DEATH 8-1-65 8:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE/MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL INC				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1101 Orleans St			
5. SEX F	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED	8. DATE OF BIRTH 1-30-25	9. AGE (In years lost birthday) 38	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES COLBERT			14. MOTHER'S MAIDEN NAME BEATRICE BOWMAN				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Chart		ADDRESS	
18. 581.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Hepatic failure (B) Portal Cirrhosis (C) Chronic alcoholic hepatitis		INTERVAL BETWEEN ONSET AND DEATH 5 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 28 1965 to Aug 1 1965 that (I) (we) last saw the deceased alive on Aug 1 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ruperto Manankil M.D.				23B. DATE SIGNED 8-1-65			
23C. PHYSICIAN'S NAME (Type) RUPERTO MANANKIL M.D.				23D. ADDRESS MERCY Hosp INC			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/5/65		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1965		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR ADDRESS Adolphus Halstead 1206 W North Ave			

MERCY HOSPITAL INC

BALTIMORE
NOT DELIVERED

NEGRO SEPARATED 1-30-58

BALTIMORE MD

JAMES COLBERT

BEATRICE BOWMAN

Chronic rheumatic nephritis
Posterior Glaucoma
Diabetic facies

and 1st of 58

Reported March 11
Reported March 11

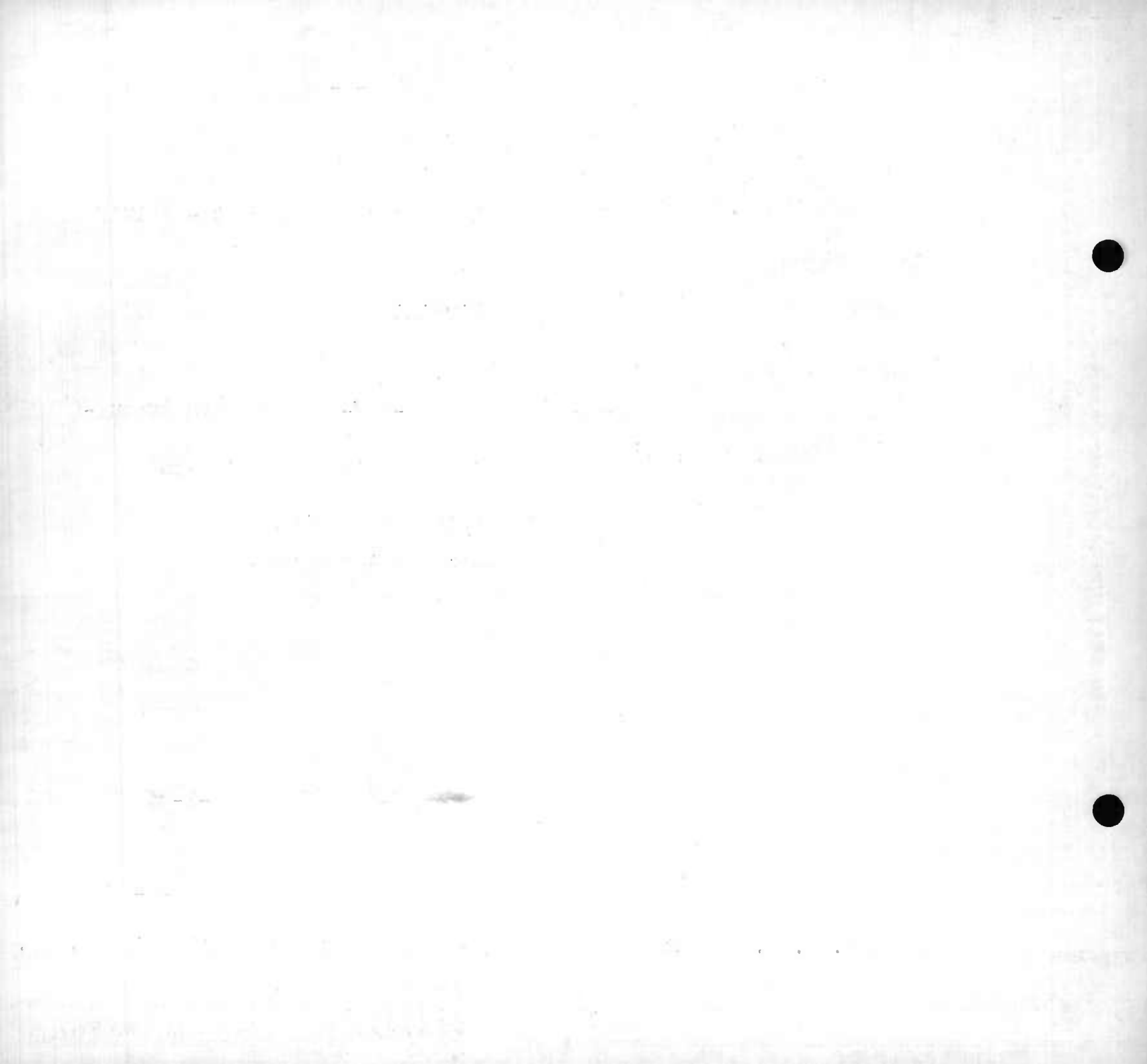
MERCY HOSP INC

44-07-81 IB

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>K-520 65 8057</u>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 8057</u>	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>John King</u>				2. DATE AND HOUR OF DEATH <u>8-1-65</u> <u>3:30 P</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>15-01</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland-#21224</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>1416 Presstman Street - #21217</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>85</u>	9. AGE (In years last birthday) <u>85</u>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-01-1630</u>		17. INFORMANT ADDRESS <u>RECORDS-BCH-4940 Eastern Avenue-#21224</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>420.1 I</u> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Arteriosclerotic Heart Disease</u> DUE TO (B) <u>Myocardial Infarction</u> DUE TO (C) <u>Congestive Heart Failure</u>			
19. DATE OF OPERATION <u>2</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Yes</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7-6-1965</u> to <u>8-1-1965</u> , that (I) (we) last saw the deceased alive on <u>8-1-1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>H. D. Albert</u>				M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8-1-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. H. D. Albert</u>				23D. ADDRESS <u>#21224</u> <u>BCH-4940 Eastern Avenue-Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/5/65</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt Calvary Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>A A County Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 4 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>H. Holstead</u>		ADDRESS <u>1206 W. North Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8058				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8058	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH					
ZULAU, ETHEL MAE		2 AUG, 1965 11:30 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
UNIVERSITY HOSPITAL				MD. 27-19			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTO.			
				D. STREET ADDRESS (If rural, give location)			
				2806 W. ROGERS AVE.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months; Days	If Under 24 Hrs. Hours; Min.	
FEMALE	White	Widowed	1901	64			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
SALES-Dept.				BALTO, MD.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
GEORGE PFEIFER				FLORENCE DOLAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				216-09-4051		Mrs. Eileen D. Kinsey 2814 Cheswolde Road	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) DUE TO		1 yr.	
				(B) DUE TO		1 yr.	
				(C) DUE TO			
19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
18 Jun 65		Intestinal Obstruct.					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7 June 1965 to 2 Aug. 1965, that (I) (we) last saw the deceased alive on 2 Aug. 1965 and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (and not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
J. Ward Kurad						2 Aug.	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
J. Ward Kurad							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/6/65		New Cathedral Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME of REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 4 1965		Robert E. Talbot		6 Ellsworth Armscoast		Ellsworth Armscoast 4600 Liberty Heights	

1825

1825

1825

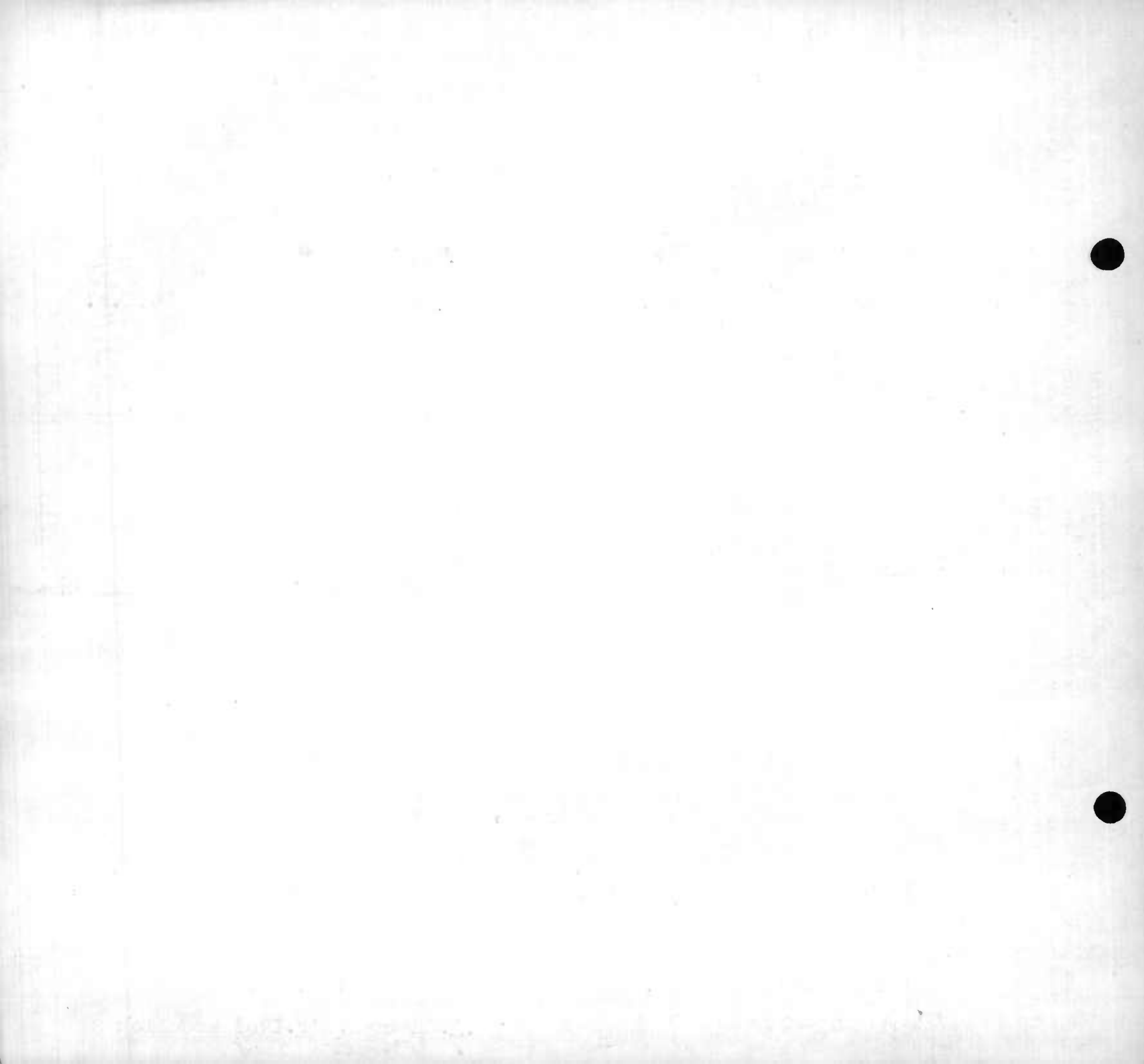
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

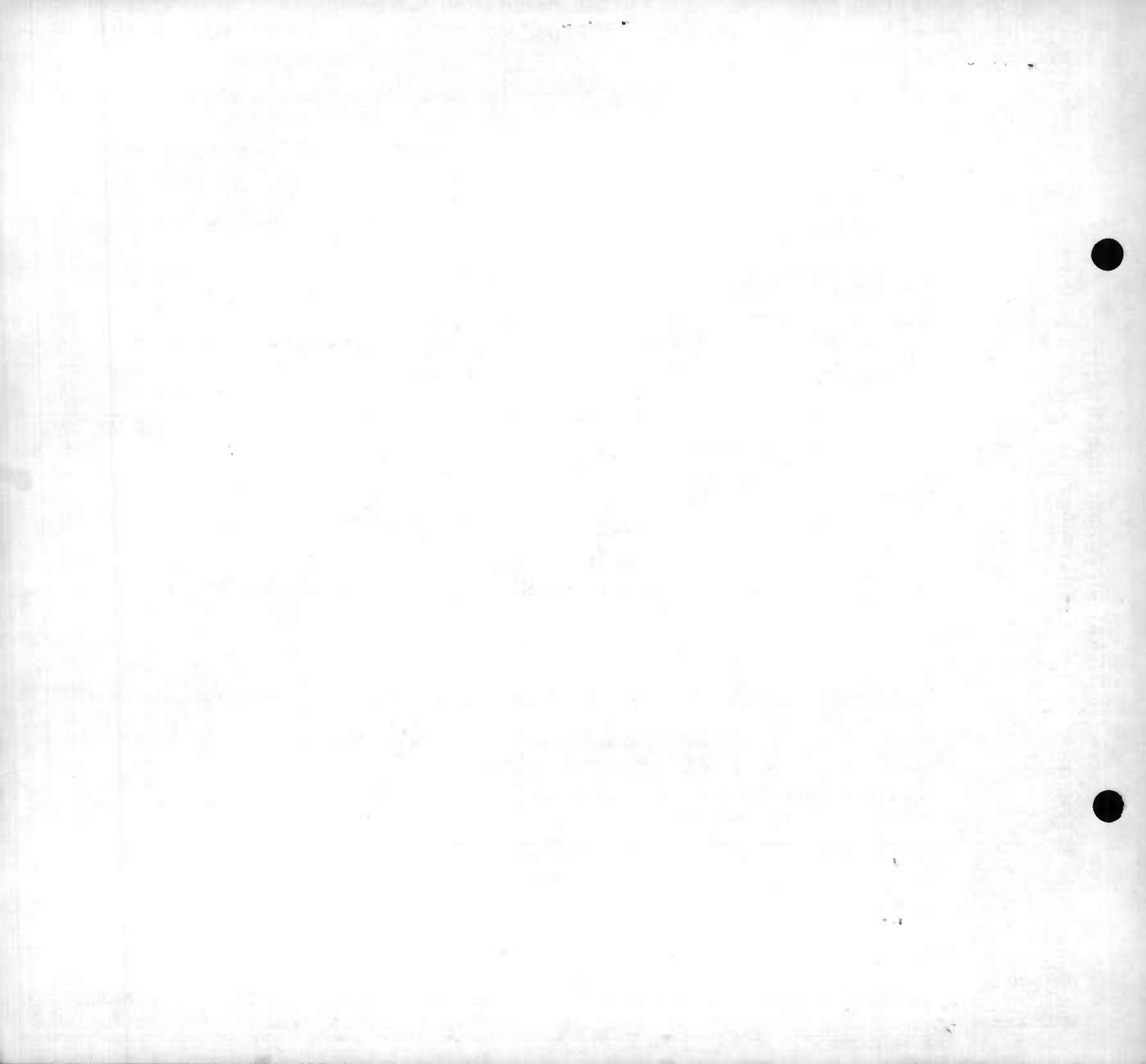
BIRTH NO. 65 8059				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8059	
1. NAME OF DECEASED (Type or Print) Robert Thomas				2. DATE AND HOUR OF DEATH July 31, 1965 10:00 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 725 George Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Nov. 10, 1900	9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		10B. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Thomas				14. MOTHER'S MAIDEN NAME Mary ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218 07 4770		17. INFORMANT ADDRESS Arnetta Palmer 242I Eutaw Pl.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 527.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Malnutrition (A) DUE TO Dehydration (B) DUE TO Emphysema of right lung (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 15, 1965 to July 31, 1965, that (I) (we) last saw the deceased alive on July 31, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE B. Tayag				23B. DATE SIGNED August 2, 1965		23C. PHYSICIAN'S NAME (Type) B. Tayag	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/6/65		24C. NAME of CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1965		25B. NAME OF REGISTRAR W. I. Chatman, Jr.		25C. FUNERAL DIRECTOR W. I. Chatman, Jr.		25D. ADDRESS 170I McCulloh St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO. 76599 8060					CERTIFICATE OF DEATH						
M.E. CASE NO. 76599 8060					Registered No. 65 8060						
1. NAME OF DECEASED (Type or Print) Mrs. Fritz Louise N.					2. DATE AND HOUR OF DEATH 8/3/65 9 ⁰⁰ A.M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Bon Secours Hospital FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 20-25 West Fayette St. BALTIMORE, Md., 21223					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 24-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 30 D. STREET ADDRESS (If rural, give location) 1147 RIVER SIDE AVE.						
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH May 2, 1878	9. AGE (In years last birthday) 87	10. If Under 1 Yr. Months: Days: Hours: Min.		11. If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) BALTIMORE, Md.		12. CITIZEN OF WHAT COUNTRY? United States				
13. FATHER'S NAME Koltenbach, John					14. MOTHER'S MAIDEN NAME MARY WAGNER						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Family - Same ADDRESS						
18. E904.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) DUE TO Bronchopneumonia (B) DUE TO arteriosclerotic disease (C) fractured hip left. approved by the medical examiner.					INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1147 Riverside Ave. 24-02						
21D. TIME OF INJURY (APPROX.) 7 10 15 AM			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Apparently fell						
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE J. J. Smith					M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Aug 3-65.				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.O.						
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 8-6-65		24C. NAME of CEMETERY or CREMATORY Holy Cross		24D. LOCATION (City, town, or county) (State) BALTIMORE					
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR McCoy		25D. ADDRESS 130 E. Fort St. - 30					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Cumberland, Md. 65 8061				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8061	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) PEGGY STAFFORD		2. DATE AND HOUR OF DEATH 8/1/65 9 40 A.M.	
1. NAME OF DECEASED (Type or Print)							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Children's Hospital, Inc.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Garnett			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Cumberland			
				D. STREET ADDRESS (If rural, give location) Rt. #2 Hinkle Rd.			
5. SEX ♀	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NO	8. DATE OF BIRTH 7-29-64	9. AGE (In years last birthday) 1yr	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John M. Stafford				14. MOTHER'S MAIDEN NAME Linda Kay Kerns			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Johnny M. Stafford		ADDRESS Cumb. Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Probable Aspiration pneumonia				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 24-36 hours.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. MULTIPLE CONGENITAL ANOMALIES						SINCE BIRTH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pierre Robin Syndrome, Gastrostomy,							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/16 19 64 to 8/1 19 65 , that (I) (we) last saw the deceased alive on 9 40/AM 8/1 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John E. Ly				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/1/65	
23C. PHYSICIAN'S NAME (Type) John E. Ly				23D. ADDRESS Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/4/65		24C. NAME OF CEMETERY OR CREMATORY Rose Hill Cern		24D. LOCATION (City, town, or county) (State) Cumberland, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Begon Right Cumb. Md.		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>6518108</u> <u>65</u> <u>8062</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65</u> <u>8062</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Marbury Baby Boy</u>		2. DATE AND HOUR OF DEATH <u>July 30, 1965</u> <u>3:53 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Church Home Hospital Nursery</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>7-6-34</u>			
5. SEX <u>M</u>		6. RACE <u>Cau</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>-</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Neonate</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John Bayne Marbury Jr</u>		14. MOTHER'S MAIDEN NAME <u>Anita Hansell</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>John Bayne Marbury Jr</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <u>Pulmonary atelectasis massive hepatic Pericardial effusion</u> (B) DUE TO <u>-</u> (C) <u>Hyaline Membrane Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 27</u> 19 <u>65</u> to <u>July 30</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>July 30</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Harvey [Signature]</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>July 30, 1965</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-2-1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cedar Hill Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Suitland, Prince Geo., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 4 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Faldut</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Joseph Gawler's Sons, Washington, D. C.</u>			

Check please a receipt for money

M Can

7/27/67

Marshall

Moneta

John Bayne Flanburg Jr Anita Howell

No

John Bayne Flanburg Jr
Anita Howell
Marshall

July 22 1967

Received
John Bayne Flanburg Jr
Anita Howell

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8063		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 8063	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) CONCETTA GUGLIUZZA			2. DATE AND HOUR OF DEATH AUG 1 1965 5 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) HARFORD CONV. HOME 4700 HARFORD RD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) (RURAL) OVERLEA 53-00 D. STREET ADDRESS (If rural, give location) 7519 BELAIR RD		
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH FEB 11 1876	9. AGE (In years last birthday) 89	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10B. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? 1st PAPERS
13. FATHER'S NAME BERAARD SABATINO			14. MOTHER'S MAIDEN NAME MARIANNA ONORATO		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT BERNARD GUGLIUZZA 31 BELHAVEN DR		
18. 491X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Granchopneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 week
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 16 1965 to August 1 1965 , that (I) (was) last saw the deceased alive on July 16 1965 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) view the body after death.					
23A. SIGNATURE A. Allan Spies			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/2/65
23C. PHYSICIAN'S NAME (Type) A. ALLAN SPIES			23D. ADDRESS 1506 PENTTERIDGE ROAD		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 8/4/65	24C. NAME of CEMETERY or CREMATORY PARKWOOD CEMETERY		24D. LOCATION (City, town, or county) (State) TAYLOR AVE. BALTO. MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR 965000		25C. FUNERAL DIRECTOR INC ADDRESS DPALETTI BROS 720 BELAIR RD	

REMARKS

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A ALAN SPIES 100 FENTRIDGE

100 FENTRIDGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO. <u>65-18539 65 8064</u>					CERTIFICATE OF DEATH					Registered No. <u>00 8064</u>	
1. NAME OF DECEASED (Type or Print) <u>JAMES P Arnold, Baby Boy</u>					2. DATE AND HOUR OF DEATH <u>8-1-65</u> <u>2:18 A.M.</u>						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>						
FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>5300</u>						
					D. STREET ADDRESS (If rural, give location) <u>1742 Lempydale Terrace</u>						
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never married</u>		8. DATE OF BIRTH <u>7-28-65</u>	9. AGE (In years last birthday) <u>03</u>	If Under 1 Yr. Months Days Hours Min. <u>0 3</u>		If Under 24 Hrs. Hours Min. <u>03</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Mercy Hospital - Baltimore</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Paul Arnold</u>					14. MOTHER'S MAIDEN NAME <u>Shirley Arnold Look</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT ADDRESS <u>None</u>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>7-24-65</u> I (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH (A) DUE TO <u>Congenital Heart Disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO						
					(C) DUE TO						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					<u>None</u>						
19A. DATE OF OPERATION <u>None</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <u>No</u>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21C. WHERE DID INJURY OCCUR? <u>None</u>			(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) <u>None</u>			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work <u>None</u>		21F. HOW DID INJURY OCCUR? <u>None</u>						
22. I certify that the (this hospital) attended the deceased from <u>7-30 at 1:30 am</u> 19 <u>65</u> to <u>8-1 2:18 am</u> 19 <u>65</u> . that (I) was last saw the deceased alive on <u>8-1 2:18 am</u> 19 <u>65</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.											
23A. SIGNATURE <u>Tom Austin</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>8-1-65</u>			
23C. PHYSICIAN'S NAME (Type) <u>TOM AUSTIN</u>					M.D. <u>JOHNS HOPKINS HOSPITAL</u>						
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/2/65</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge</u>			24D. LOCATION (City, town, or county) (State) <u>Pikesville 8 Ind</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 4 1965</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>			25C. FUNERAL DIRECTOR <u>Living Byrne Fun Home</u>					
						ADDRESS <u>8728 Liberty Rd Randallstown Md</u>					

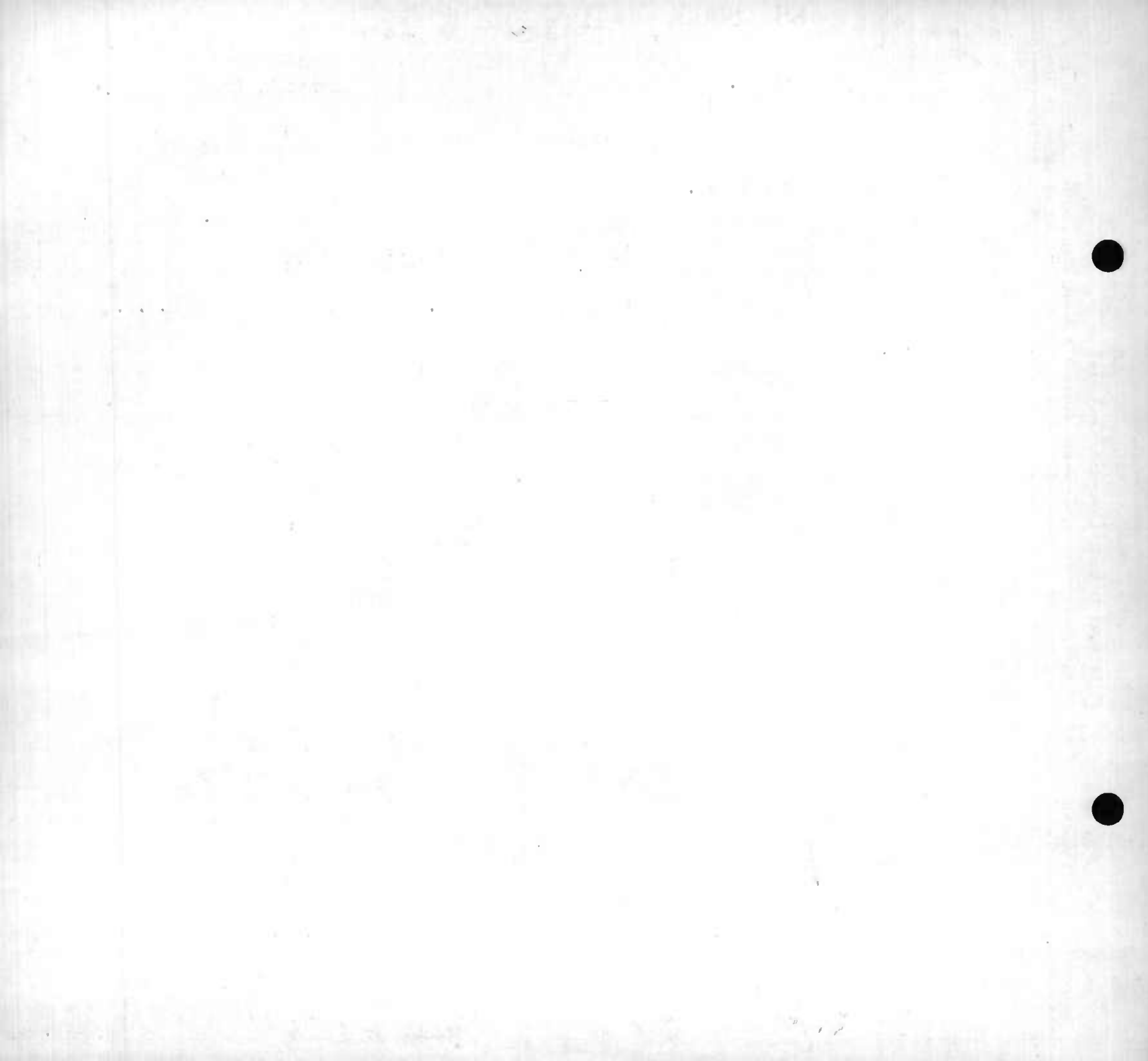
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
65 8065		65 8065		65 8065	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED	
				Archibald W. MacLellan	
2. DATE AND HOUR OF DEATH		August 1, 1965		9:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give address or location)		Maryland		B. COUNTY	
3536 Roland Ave.		Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
		Baltimore		D. STREET ADDRESS (If rural, give location)	
		3536 Roland Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
male	White	Widowed	11/14, 1867	97	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
		Printer		Conn.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Unk.		Unk.		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		219-16-6543		Margaret MacLellan 3536 Roland Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		6 yrs	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from		1955 to 8-1-1965			
that (I) (we) last saw the deceased alive on		8-1-1965		and that in (my) (our) opinion death occurred on the date	
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Z. Vance Hooper				8-2-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Z. Vance Hooper		3534 Ellerslie Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8/5, 1965		Lorraine Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 4 1965		Robert E. Fisher		Frank W. Seitz	
				ADDRESS	
				814 W. 36th. St.	



1		61-18772		BALTIMORE CITY HEALTH DEPARTMENT		65 8066	
BIRTH NO. 65 8066		MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD			
		ROBERT CUMMINGS Jr.		July 31, 1965		5:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland			
37 Mercy Hospital				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
				Baltimore		14-01	
				D. STREET ADDRESS (If rural, give location)			
				1604 Bolton Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
Male	Caucasian		May 28, 1961	4e			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				Maryland			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Margaret Cook			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
				Margaret H. Cummings		1604 Bolton St.	
18. 002,3 I		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Chronic Brain Syndrome					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO					
ANTECEDENT CAUSES		(B) Viral Encephalitis.					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO					
		(C)					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No		No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22.		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		Charles S. Petty		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		Charles S. Petty		M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
						ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Burial		8/4, 1965		Woodlawn		Baltimore, Md.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS	
AUG 4 1965		Robert E. Taylor		Frank A. Petty		814 W 36th St	

WALMLEY BROS

GRANTON

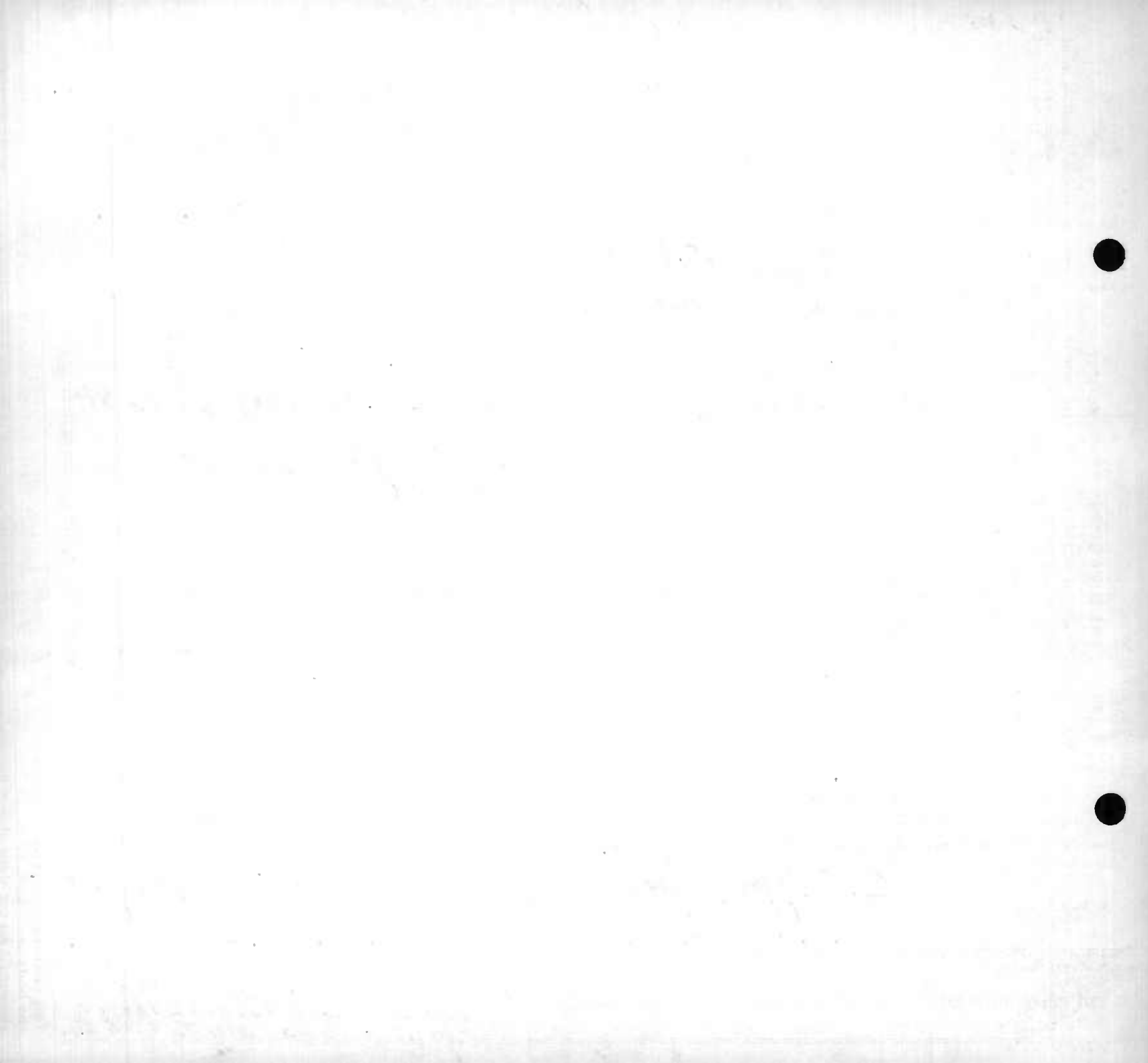
1891

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

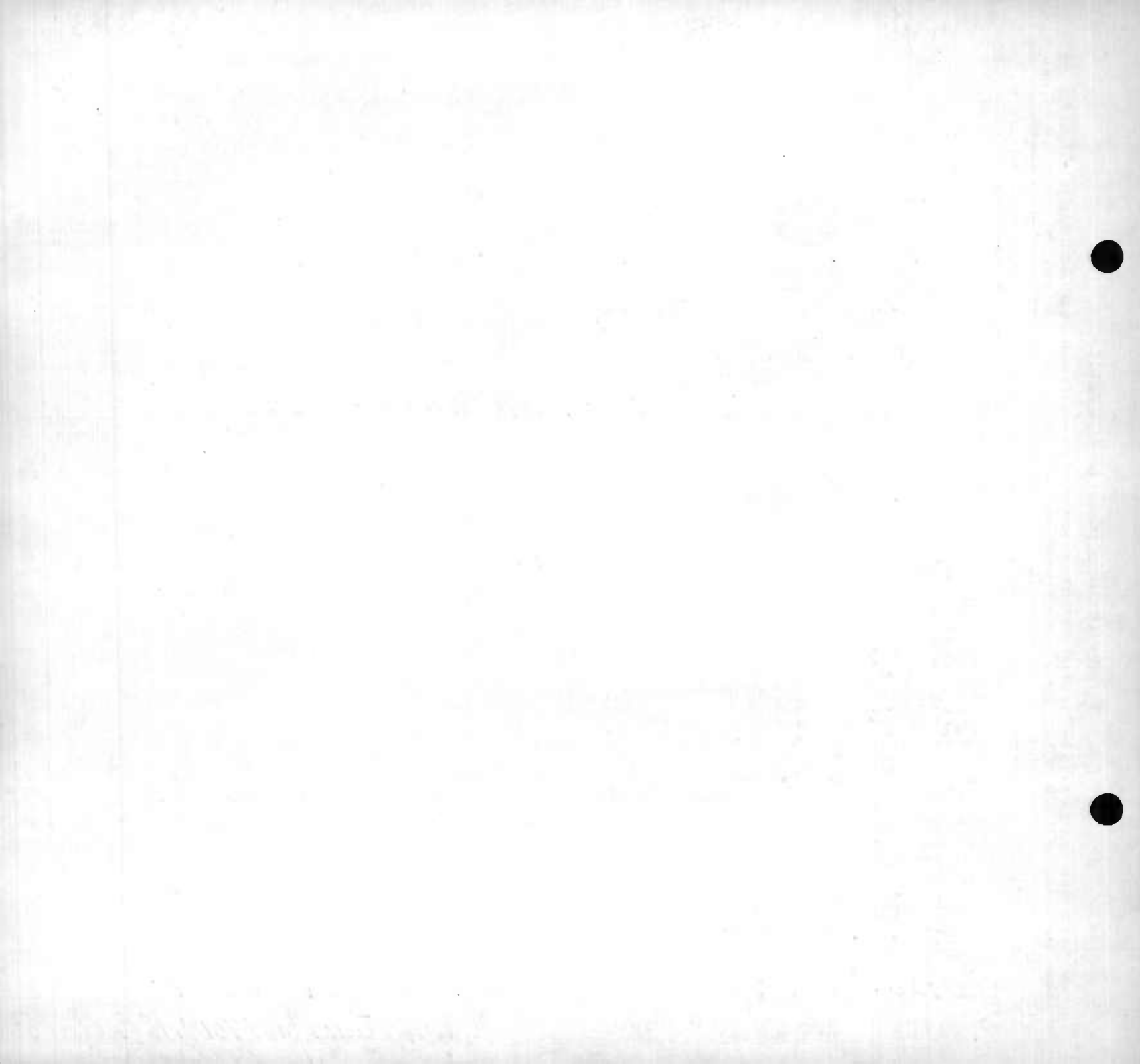
BIRTH NO. 65 8067		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8067	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Frank Smith			2. DATE AND HOUR OF DEATH 8/2/65 6:55 a.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1811 Spence Street Balto. 30, Md.		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 11/10/97	9. AGE (In years last birthday) 68	10. Under 1 Yr. Months Days 11 Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10B. KIND OF BUSINESS OR INDUSTRY Refrigeration		11. BIRTHPLACE (State or foreign country) MAINE 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bertie R. Smith			14. MOTHER'S MAIDEN NAME Myra F. Bean		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No none		16. SOCIAL SECURITY NO. ?		17. INFORMANT Mrs. DAHNKE 1809 Spence St.	
18. 141.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO Carcinoma of Tongue & metastases (B) DUE TO (C)		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 7/21/65 19 to 8/2/65 19, that (we) last saw the deceased alive on 8/2/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. E. Jones, Jr.			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/2/65
23C. PHYSICIAN'S NAME (Type) C. E. JONES, JR., MD.			23D. ADDRESS South Balto. Gen. Hosp. - 1213 Light St.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-3-65	24C. NAME OF CEMETERY or CREMATORY Cambridge		24D. LOCATION (City, town, or county) (State) Cambridge MASS.	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Geo. L. Schwab Funeral Home Phonics W. Miller 2101 Frederick Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

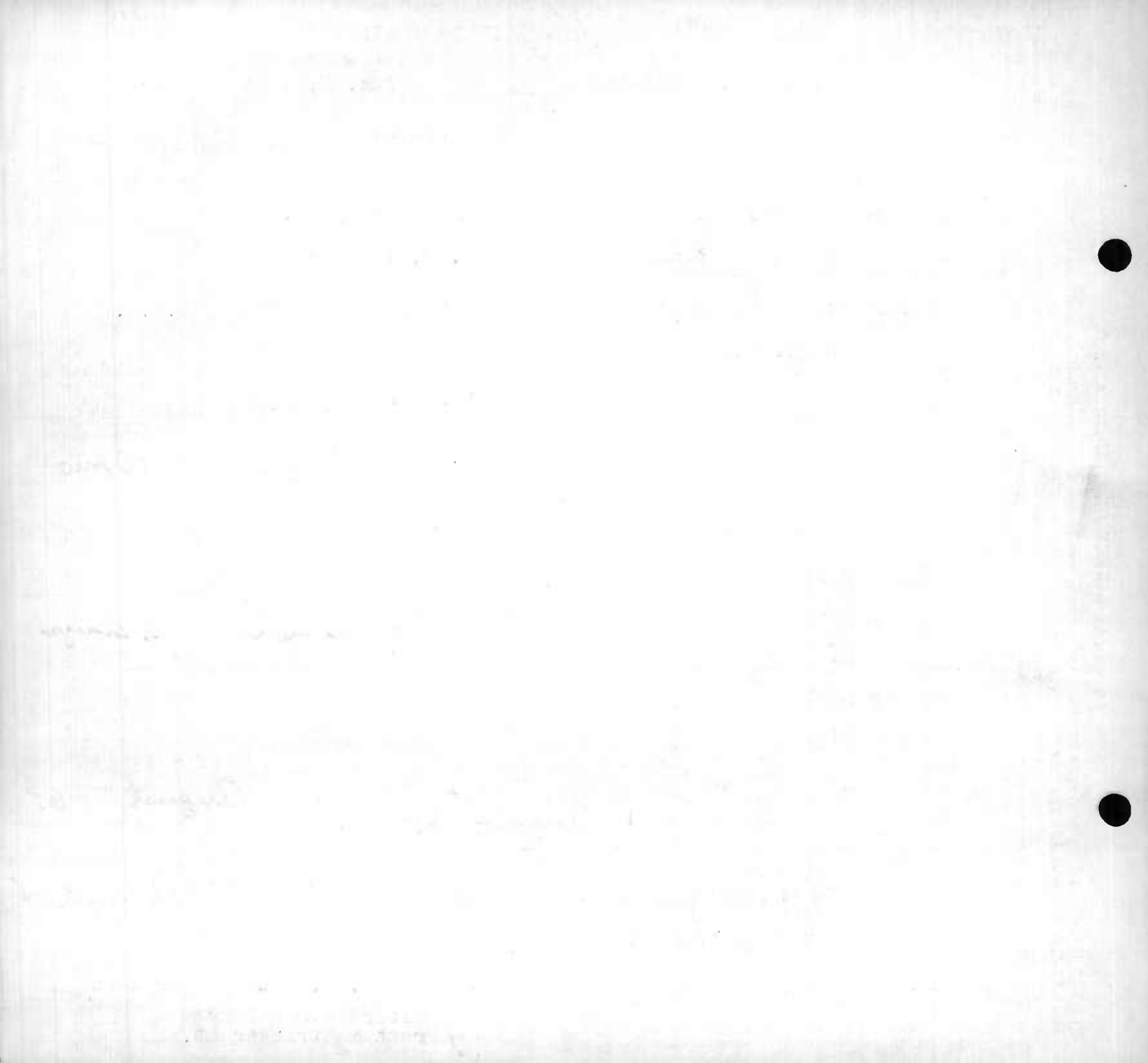
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8068	
BIRTH NO. 65 8068		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED <i>Richard Blair Anderson</i>		2. DATE AND HOUR OF DEATH <i>Aug 2, 1965 1040 A.M.</i>	
(Type or Print)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>17-03</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
				D. STREET ADDRESS (If rural, give location) <i>800 Harlem Ave</i>	
5. SEX <i>M</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Oct 28, 1904</i>	9. AGE (In years last birthday) <i>60</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Factory Worker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Factory</i>		11. BIRTHPLACE (State or foreign country) <i>Va</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John Anderson</i>		14. MOTHER'S MAIDEN NAME <i>Louise Bolding</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>218-07-1573</i>		17. INFORMANT <i>Elsie Blackwell 20 Viennast.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <i>157X I</i>		CAUSE OF DEATH <i>Rochester, N.Y.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <i>Carcinoma of the Pancreas</i> DUE TO		<i>5 days</i>	
		(B) <i>Acute Renal Failure</i> DUE TO		<i>5 days</i>	
		(C) <i>Dehydration</i> DUE TO		<i>5 days</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>Aug 1, 1965</i> to <i>Aug 2, 1965</i> , that (I) (we) last saw the deceased alive on <i>Aug 2, 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>H.C. Standiford M.D.</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>Aug 2, 1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>H. C. Standiford</i>		M.D.		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/8/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus mem. P.K. Balto. Md.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 4 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>W. J. Blum</i>		ADDRESS <i>1701 McCall St Baltimore</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

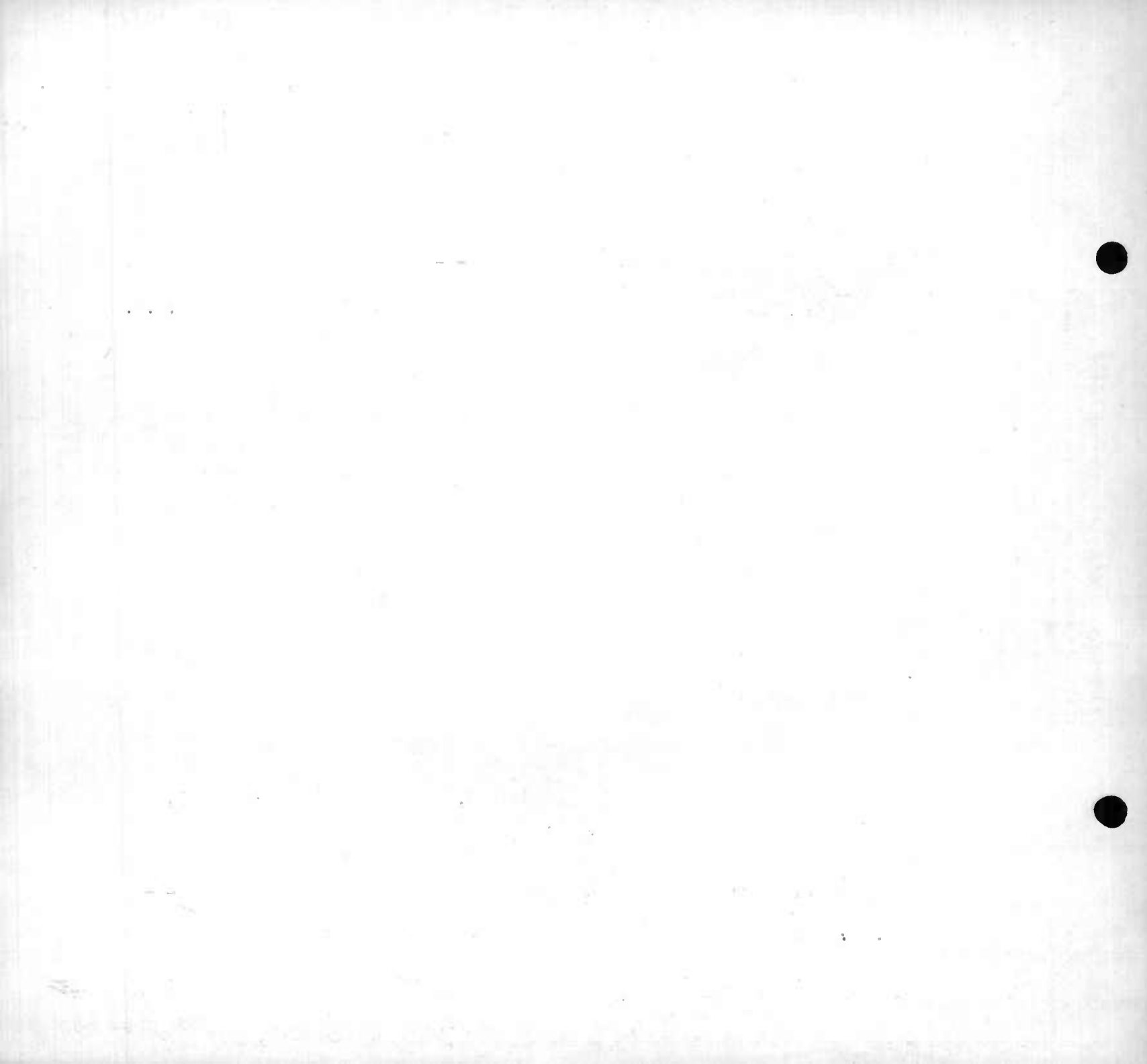
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 5		8069	
BIRTH NO. 65 8069		CERTIFICATE OF DEATH					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		Pietro P. Gugliette		Aug. 2, 1965		1:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
1345 Ramsey St.				Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore City			
				D. STREET ADDRESS (If rural, give location)			
				1345 Ramsey St.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Apr. 6, 1880	9. AGE (In years last birthday) 85	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Machinist		Railroad		Italy		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Gugliette							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				Josetta Showalter-1345 Ramsey St.			
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				A. DUE TO		10 mo	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				B. DUE TO			
				C. DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				B. DUE TO		8 days	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from October 1964 to August 1965, that (I) (we) last saw the deceased alive on August 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
H. H. Baylus						3 August 65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
H. H. BAYLUS				1600 WILKENS AVE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/5/65		Cedar Hill Cem.		A. A. County Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
AUG 4 1965		Robert E. Talley		Walters Funeral Home			
				Pratt & Stricker St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

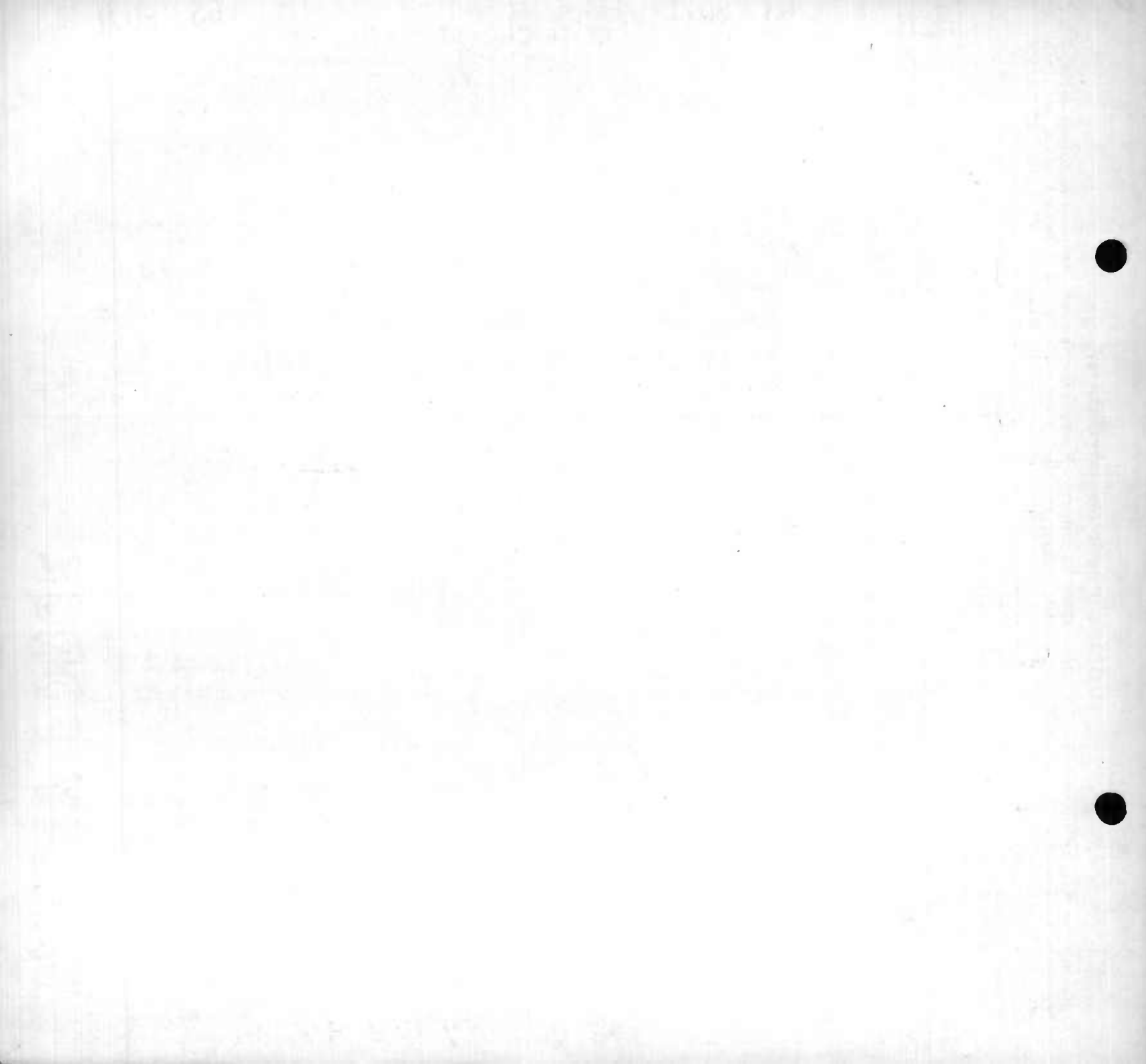
BIRTH NO. 65 8070				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8070	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Thomas Brooks Lacy				2. DATE AND HOUR OF DEATH August 3, 1965 8:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland				A. STATE Maryland B. COUNTY 15-04			
5. SEX Male				6. RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH 5-5-1890		9. AGE (In years last birthday) 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		11. BIRTHPLACE (State or foreign country) Warrenton, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Richard Brooks		14. MOTHER'S MAIDEN NAME Alice Lacey		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes	
16. SOCIAL SECURITY NO. 215-28-7123		17. INFORMANT Mary Brooks		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(A) CARCINOMA LIVER. (METASTATIC).		(B) DUE TO		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION 7.29.65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA. LIVER-BIOPSY		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from July 9, 1965 to August 3, 1965, that (I) (we) lost saw the deceased olive on August 3, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE V.S. Rao		23B. DATE SIGNED 8-3-65		23C. PHYSICIAN'S NAME (Type) V. S. Rao		23D. ADDRESS 1514 Division Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-6-1965		24C. NAME of CEMETERY or CREMATORY Balto Nat Cmt		24D. LOCATION (City, town, or county) Balto Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Gray & Wilson		25D. ADDRESS 1000 Brantly Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 8071		65 8071		65 8071	
<div> <div> <div>5-536</div> <div>CERTIFICATE OF DEATH</div> </div> </div>					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Margaret Elizabeth Saunders			July 30, 1965 4:55 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
University Hospital Baltimore, Md., 21201			Maryland 18-01		
5. SEX			6. RACE		
F			N		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)			8. DATE OF BIRTH		
W			3/22/1878		
9. AGE (In years last birthday)			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
87					
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Maryland			USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Moriss Moore			Nellie Campbell		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT			ADDRESS		
Mrs Julia Harrison			804 W. Lexington St		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
465X1			Pulmonary embolus		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION			20A. AUTOPSY? (Yes or No)		
2			Yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED		
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
22. I certify that (I) (this hospital) attended the deceased from July 29 1965 to July 30 1965, that (I) was last saw the deceased alive on July 30 1965 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Bernard du Buy			7/30/65		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Bernard du Buy			University of Maryland Hosp.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/3/65		CARVER Memorial Park	
24D. LOCATION (City, town, or county)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Lauri, Md.		AUG 4 1965		Robert E. Taylor	
24G. FUNERAL DIRECTOR		24H. ADDRESS		24I. ADDRESS	
William G. March		128 E. North Ave			



FUNERAL DIRECTOR: IMPORTANT

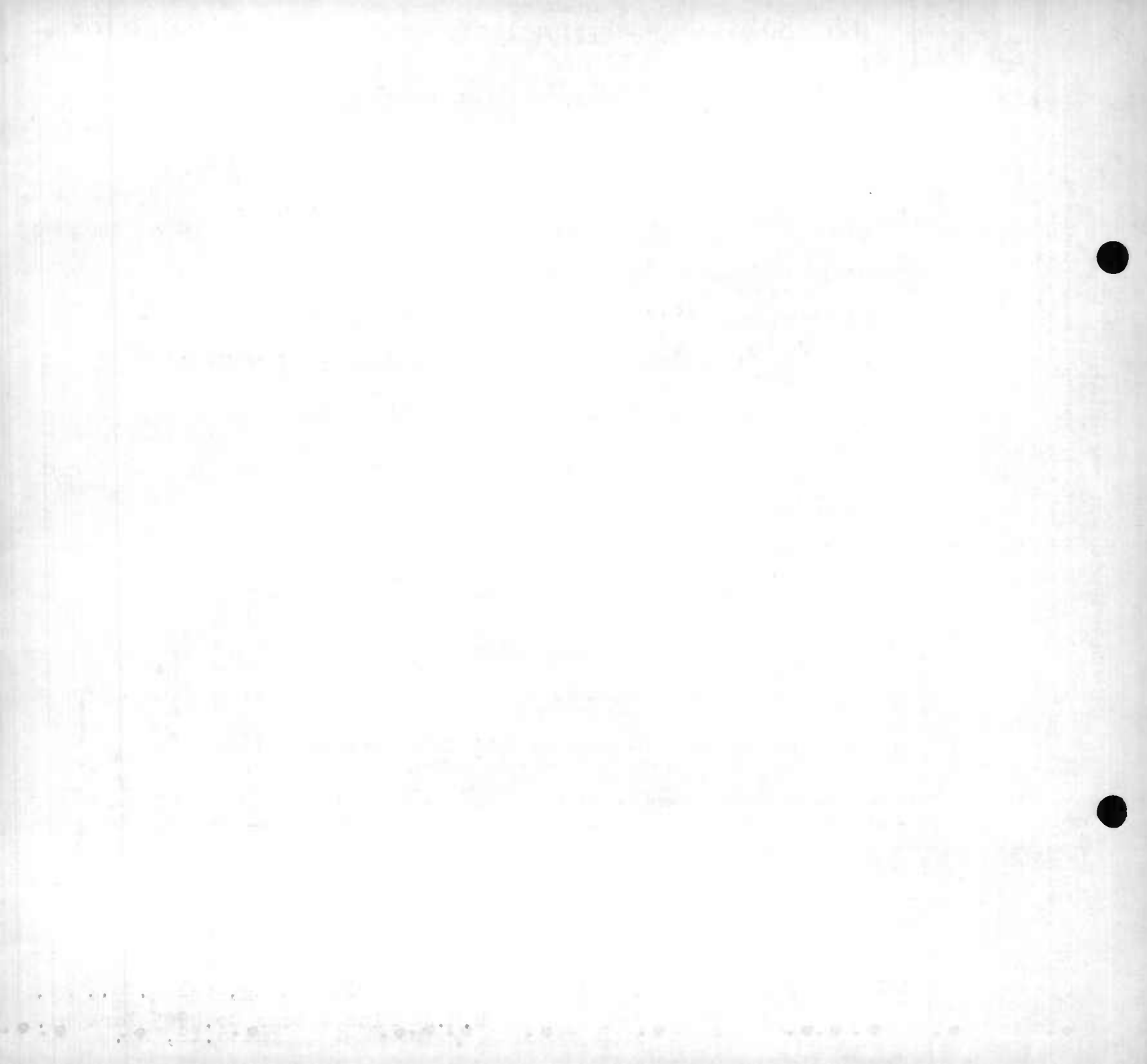
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8072	
BIRTH NO. 65 8072		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BOYER FREDERICK PENDLETON		2. DATE AND HOUR OF DEATH AUGUST 3, 1965 4:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) North Charles GENERAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE NEW YORK B. COUNTY V-29 C. CITY OR TOWN (If outside city limits, write RURAL and give township) WHITE PLAINES D. STREET ADDRESS (If rural, give location) 109 ORAWAUPUM ST.			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 3-20-31	9. AGE (In years last birthday) 34	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, Md	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME NELSON FRAZIER		14. MOTHER'S MAIDEN NAME ELIZABETH PENDLETON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT (Mother) ELIZABETH PENDLETON ADDRESS 2306 GUILFORD AVE.	
18. 4201 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) POSSIBLE MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that N (this hospital) attended the deceased from AUGUST 2, 1965 to AUGUST 3, 1965 , that N (we) last saw the deceased alive on AUGUST 3, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. N (We) (did) (did not) view the body after death.					
23A. SIGNATURE Marion Friedman M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED AUGUST 3, 1965			
23C. PHYSICIAN'S NAME (Type) MARION FRIEDMAN		23D. ADDRESS M.D. 5211 HARFORD RD, BALTIMORE, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug 7/65		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery Anne Arundel County Md.	
24D. LOCATION (City, town, or county) (State) 1129 N. Camden St.					
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1965		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Joseph E. Eulichian	

FUNERAL DIRECTOR: IMPORTANT

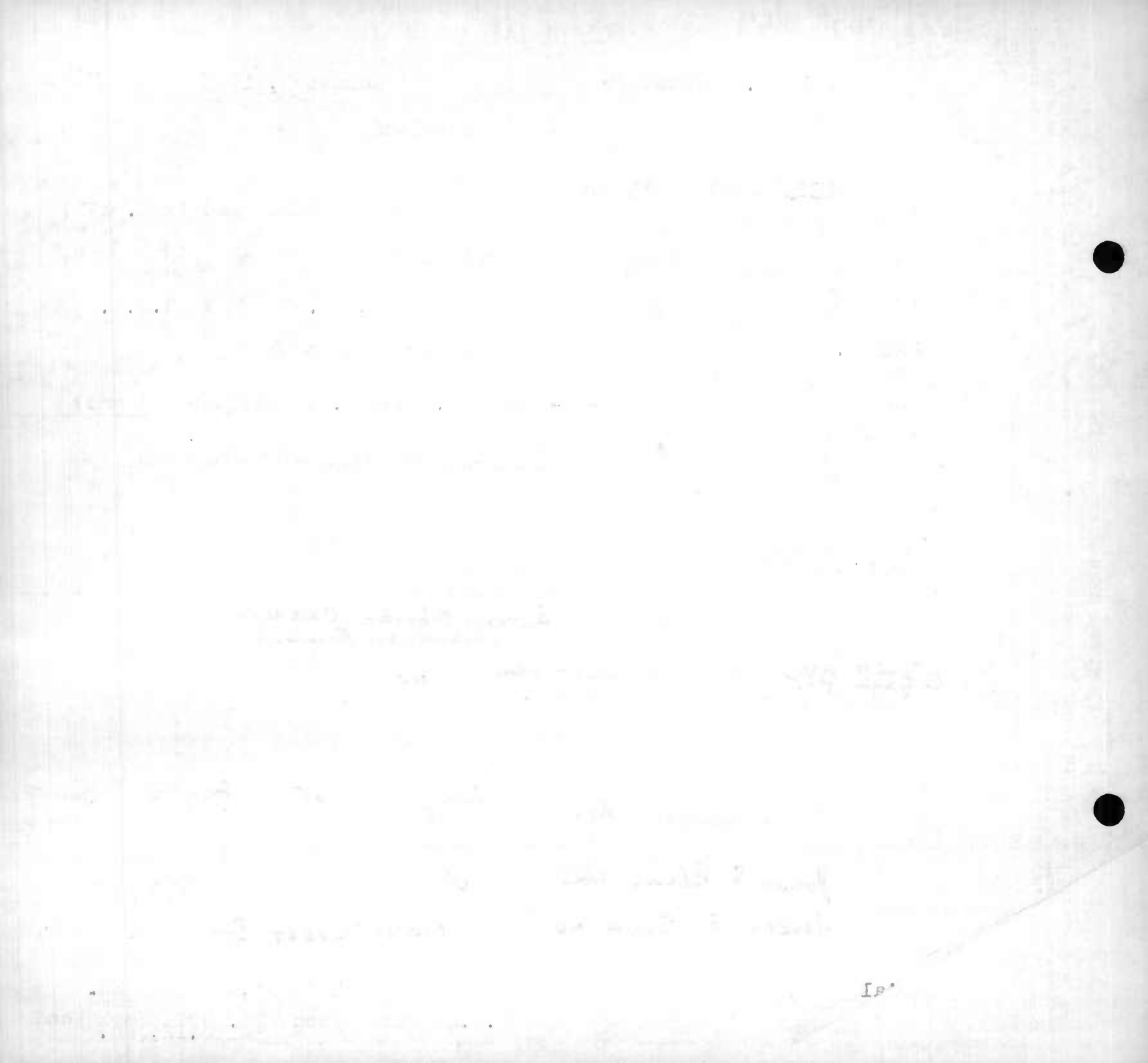
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8073	
BIRTH NO. 65 8073		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JAEGER, MARIE A.		2. DATE AND HOUR OF DEATH Aug 2 1965 12 ⁵⁵ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Md. B. COUNTY 9-02		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto 18	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Md General Hosp Balto Md.		D. STREET ADDRESS (If rural, give location) 3210 Harford Rd.			
5. SEX F	6. RACE Cau	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 3-30-89	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Armin J. JAEGER			14. MOTHER'S MAIDEN NAME Louise SIEBERT		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-30-0302	17. INFORMANT Chart ADDRESS		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 2 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 7/31 1965 to 8/2 1965, that (2) (we) lost saw the deceased alive on 8/2 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald T. Lewers MD M.D.				23B. DATE SIGNED 8/2/65	
23C. PHYSICIAN'S NAME (Type) Donald T. Lewers MD M.D.		23D. ADDRESS Md Gen Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/5/1965		24C. NAME OF CEMETERY or CREMATORY Druid Ridge	
24D. LOCATION Pikesville, Balto. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 4 1965			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25D. ADDRESS 4905 York Rd. Balto. 12, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8074		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8074	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
John H. Hofstetter		August 3, 1965		1:40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 27-09	
4323 Marble Hall Road		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		4323 Marble Hall Road (Apt. 177)	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8/15/1894	9. AGE (In years last birthday) 70	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Salesman		Lumber		Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A.		John H. Hofstetter		Margaret Lautenklos	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		215-10-5732		Mrs. Nora M. Hofstetter (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
13-3-8 I		Carcinoma - Colon - metastasis		about Jan 1965	
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II		ARTERIO Sclerotic Cardio-vascular Disease		?	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
		April 15 - 1965		Carcinoma - Colon	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1965 to Aug 3 1965, that (I) (we) last saw the deceased alive on Aug - 3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Joseph S. Blum, M.D.		8/3/65			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JOSEPH S. BLUM, M.D.		115 N. CALVERT ST. BALTO-2-MD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8/6/1965		Loudon Park	
24D. LOCATION (City, town, or county)		24E. FUNERAL DIRECTOR ADDRESS			
Baltimore, Md.		H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 4 1965		Robert E. Jenkins, M.D.			

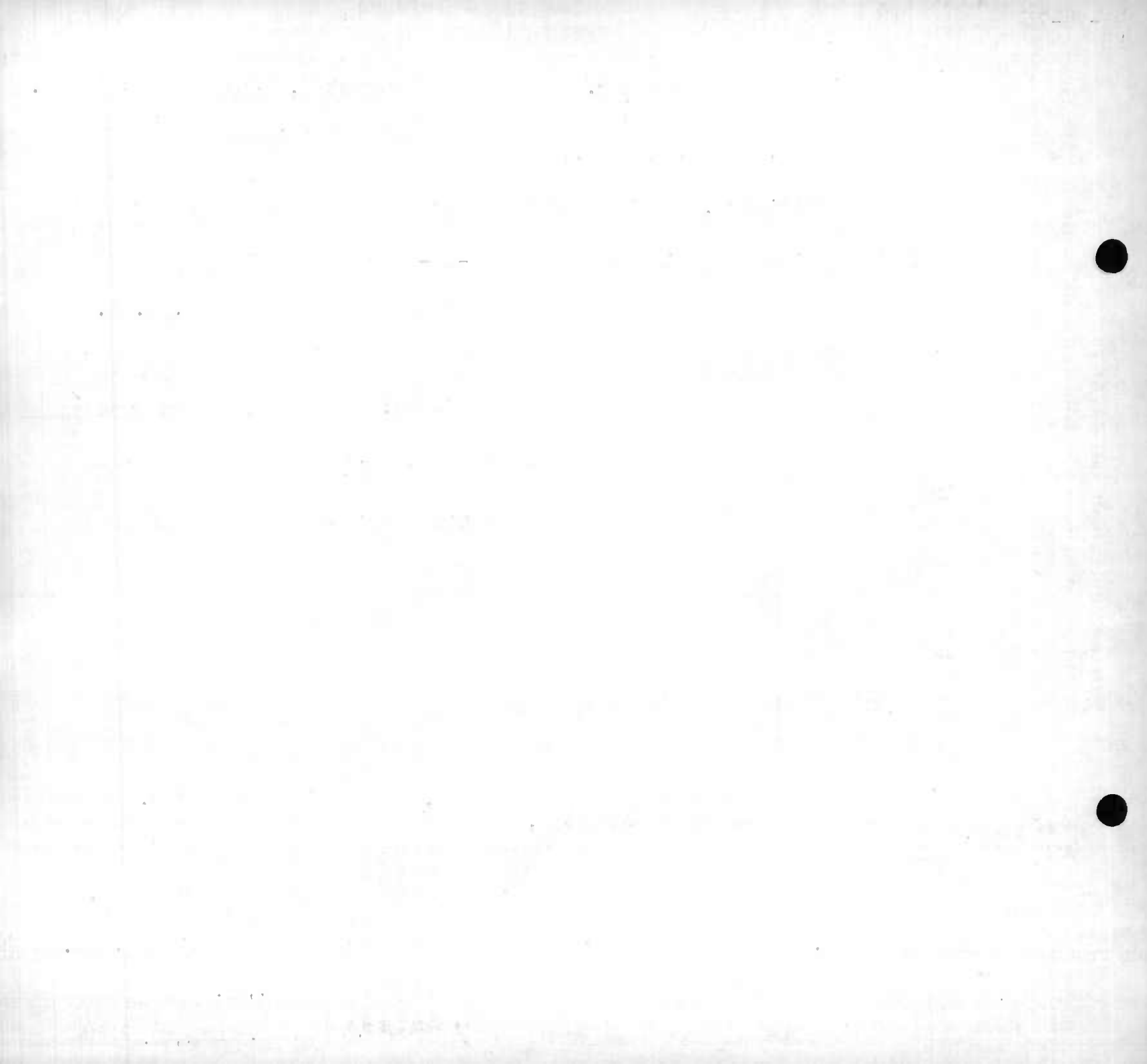


43-94-75
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FUNERAL DIRECTOR: IMPORTANT

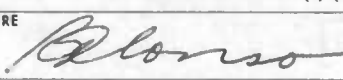
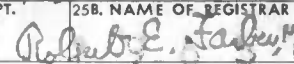
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

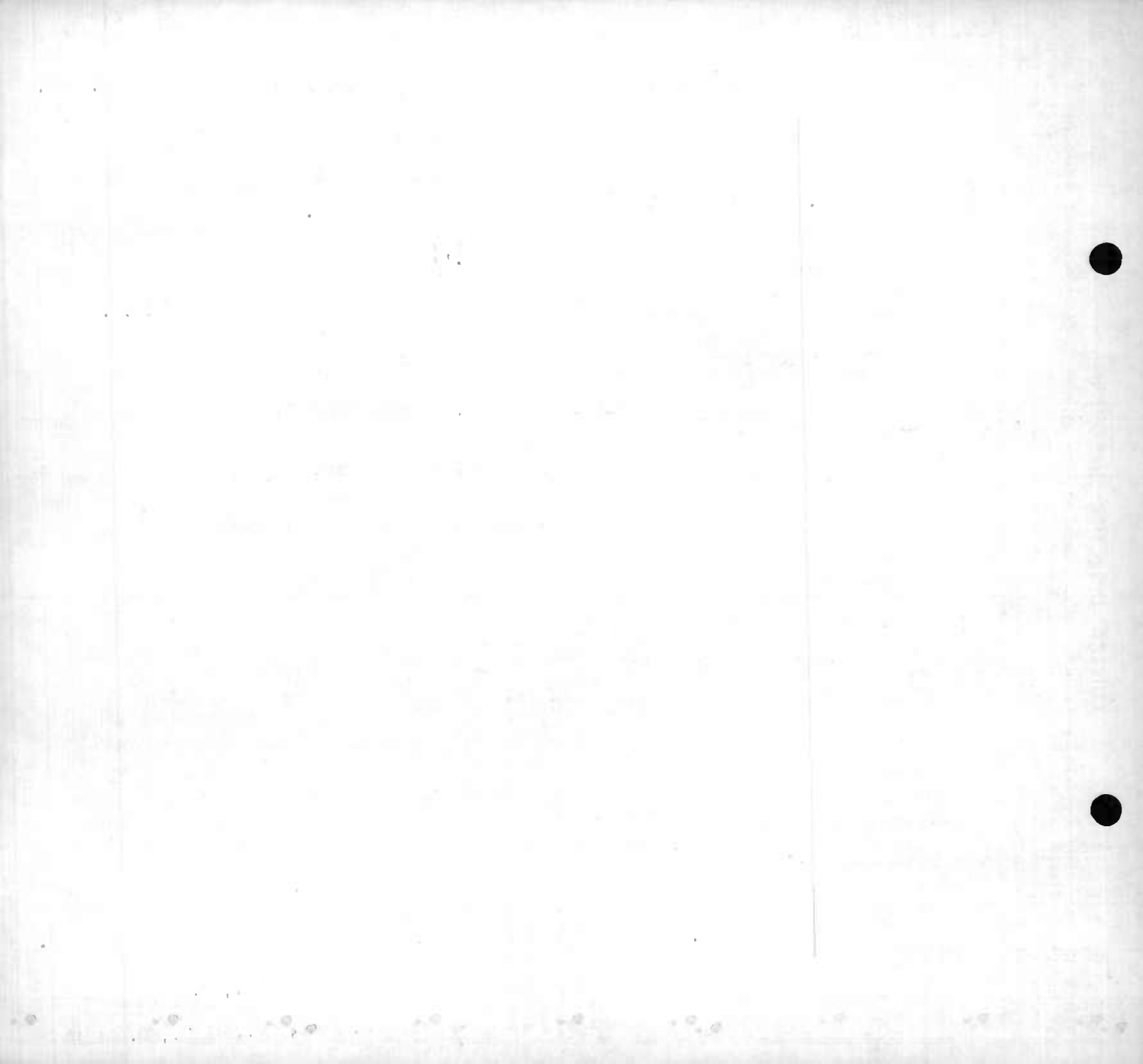
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 8075</u>	
BIRTH NO. <u>65 8075</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Louis Albert Schaum Sr.</u>			2. DATE AND HOUR OF DEATH <u>August 2, 1965</u> <u>5:20</u> <u>P.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>RURAL</u> <u>63-00</u> D. STREET ADDRESS (If rural, give location) <u>9816 Magleddt Road 21234</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>5-12-1892</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED ROUTE SALESMAN</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>LOUIS A SCHAUM</u>			14. MOTHER'S MAIDEN NAME <u>AUGUSTUS HARTMAN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>RECORDS: BCH 4940 Eastern Avenue</u>
18. <u>177X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>Respiratory Failure</u> DUE TO (B) <u>Prostatic Carcinoma</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>20 Minutes</u> <u>3 Years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Yes</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 23, 1965</u> to <u>August 2, 1965</u> , that (I) (we) last saw the deceased alive on <u>August 2, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Howard Rathbun</u>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>August 2, 1965</u>
23C. PHYSICIAN'S NAME (Type) <u>Dr. Howard Rathbun</u>			23D. ADDRESS M.D. <u>4940 Eastern Avenue Baltimore, Md. 21224</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>8/5/65</u>	24C. NAME OF CEMETERY or CREMATORY <u>GARDENS OF FAITH CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO., MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 4 1965</u>		25B. NAME OF REGISTRAR <u>LEONARD J. CRUCK</u>		25C. FUNERAL DIRECTOR ADDRESS <u>LEONARD J. CRUCK, INC. BALTO., MD. 21214</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C430 65 8076		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8076	
BIRTH NO. 65 8076		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SR. Culotta, Vincent		2. DATE AND HOUR OF DEATH August 2 1965 5:40PM.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Josephs Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 27-44 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21214 D. STREET ADDRESS (If rural, give location) 3501 White Ave.			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH nov. 14 1892	9. AGE (In years lost birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Produce Business		11. BIRTHPLACE (State or foreign country) ITALY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME PASQUALE CULOTTA		14. MOTHER'S MAIDEN NAME ROSA FAVA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-32-8896	17. INFORMANT MRS. ROSARIA CULOTTA,		ADDRESS SAME
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Ventricular fibrillation DUE TO (B) Arteriosclerotic Heart Disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 12 19 65 to August 2 19 65 , that (I) (we) last saw the deceased alive on August 2 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 2 1965	
23C. PHYSICIAN'S NAME (Type) Bernardino A. Alonso		23D. ADDRESS M.D. 1400 N. Caroline St Baltimore 21213 Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 8/6/65	24C. NAME of CEMETERY or CREMATORY HOLY REDEEMER CEMETERY		24D. LOCATION (City, town, or county) (State) BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1965		25B. NAME OF REGISTRAR 		25C. FUNERAL DIRECTOR LEONARD J. CRUCK, INC., BALTO., MD. 21214	

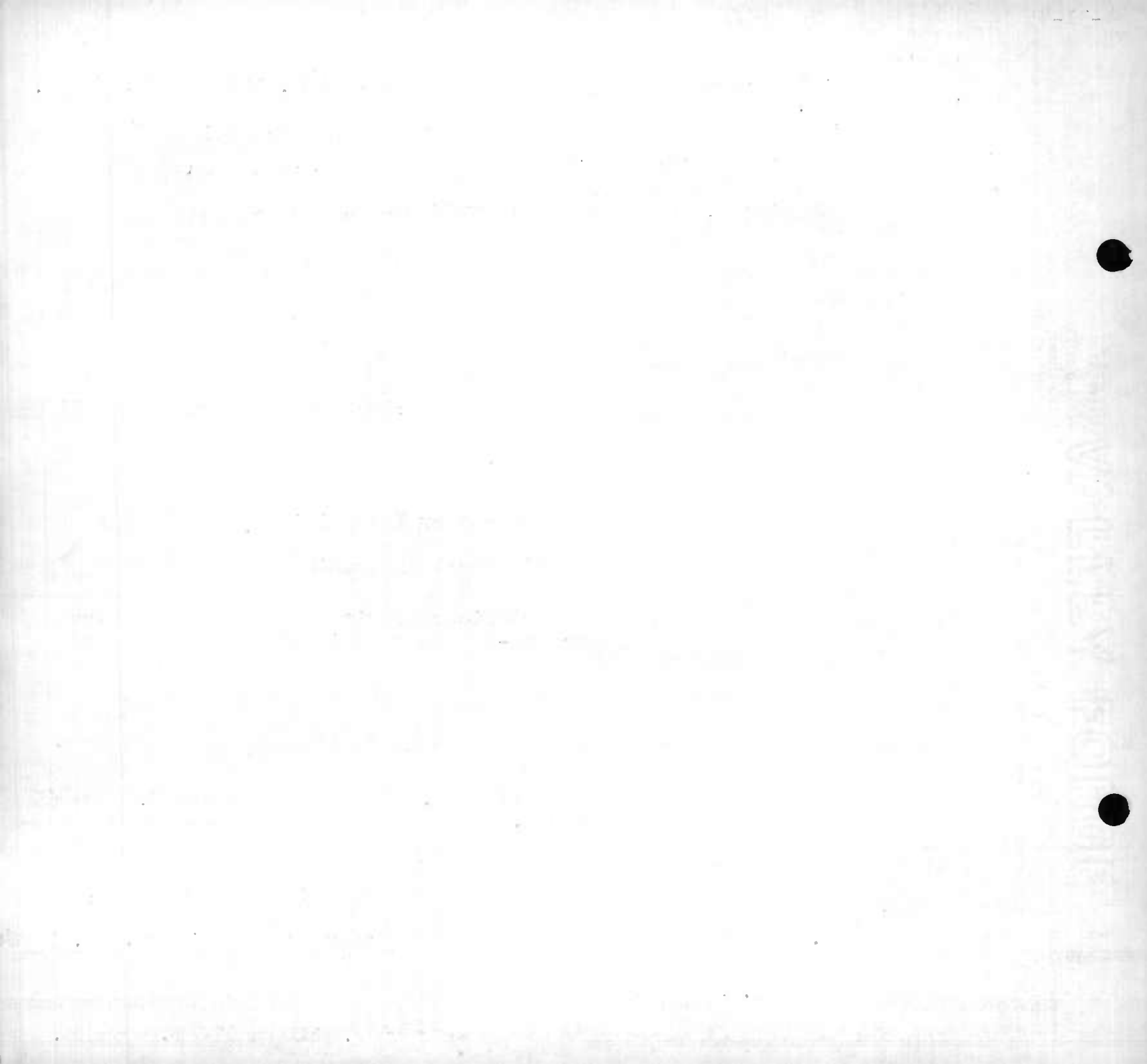


44-31-45
FR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

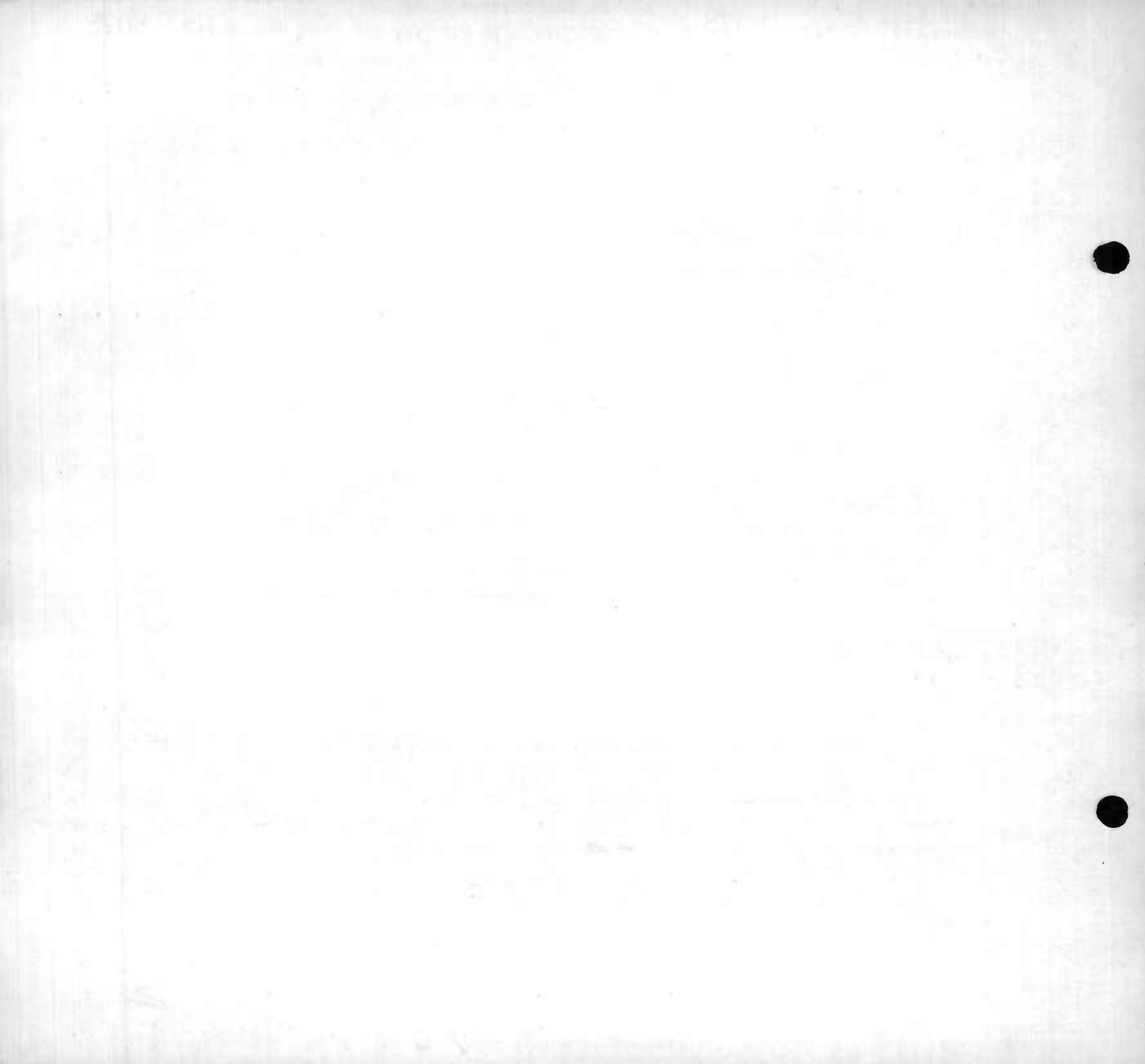
BIRTH NO. P-62065 8077				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8077	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Daniel Brooks				2. DATE AND HOUR OF DEATH August 2, 1965 4:45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel C. CITY OR TOWN (If outside city limits, write RURAL and give township) East Glen Burnie RURAL 52-00 D. STREET ADDRESS (If rural, give location) 7355 Furnace Branch Road			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1881	9. AGE (In years last birthday) 84	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224		
18. 490X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cardiac Arrest DUE TO (B) Respiratory Insufficiency DUE TO (C) Bilateral Pneumonia DUE TO INTERVAL BETWEEN ONSET AND DEATH 0 4 Days 4 Days				II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis Cerebro-Vascular Accident INTERVAL BETWEEN ONSET AND DEATH 30 Years 3 Hours			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 30, 19 65 to August 2, 19 65 , that (I) (we) last saw the deceased alive on August 2, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 2, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. Howard Rathbun				23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE Aug. 7, 65		24C. NAME of CEMETERY or CREMATORY Grace Methodist Cemetery		24D. LOCATION (City, town, or county) (State) Chapel Hill, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS Arlington S. Phillips 1727 N. Monroe St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

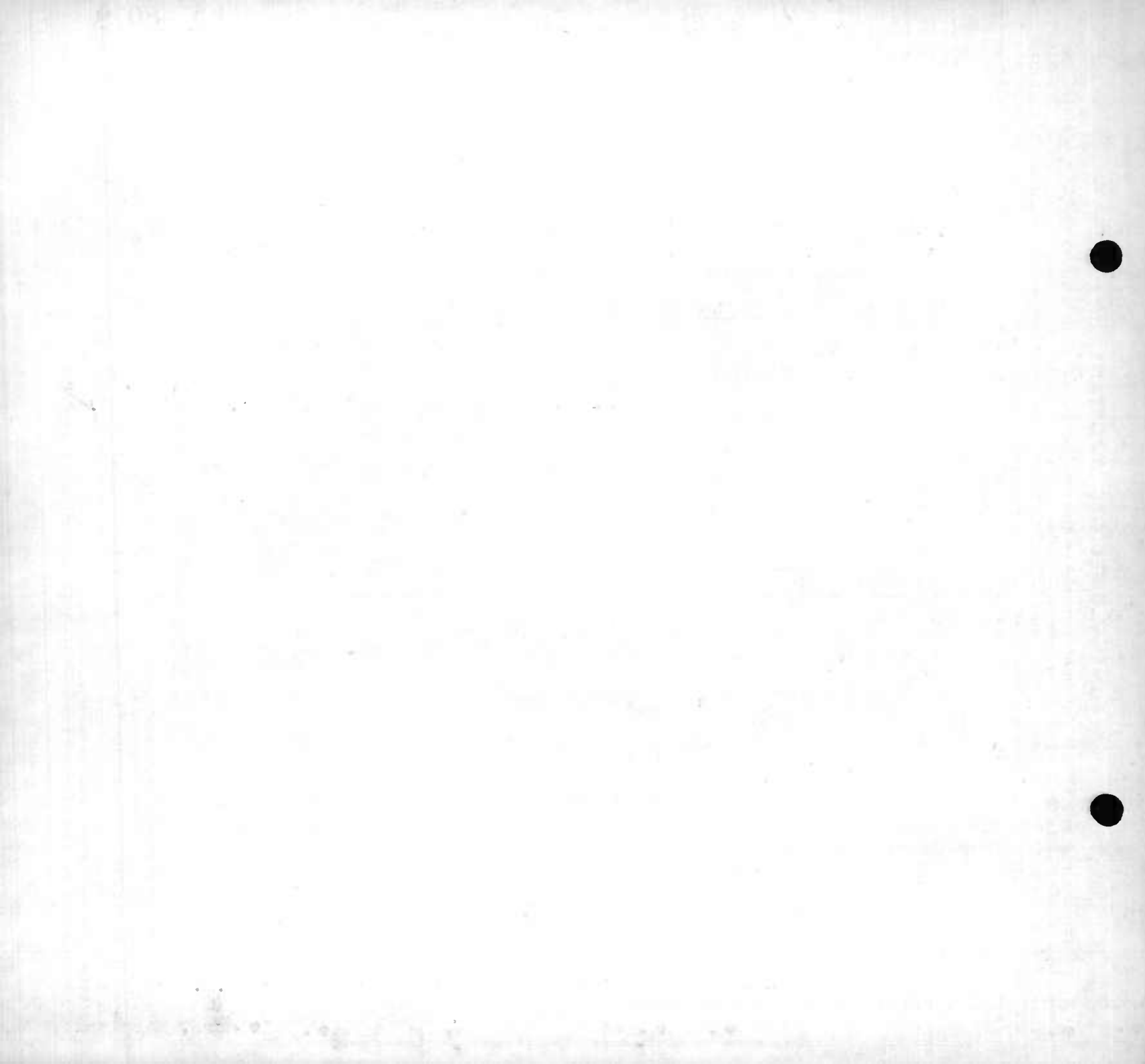
BIRTH NO. 65 8078		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8078	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Bessie Cherry			2. DATE AND HOUR OF DEATH July 31, 1965 8:45 P: M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) D. O. A. - Sinai Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 20-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2224 West Fayette Street		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10/8/1911	9. AGE (In years last birthday) 53	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina U. S. A.	
13. FATHER'S NAME Alford Butler			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-18-8246		17. INFORMANT Physician's Records	
18. 442X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Hypertensive Cardio Vascular Renal Disease DUE TO (B) Acute Cardiac Failure DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from May 17, 1963 to July 1965, that (I) (we) lost saw the deceased alive on July 1, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Robert Lee Jackson			23B. DATE SIGNED 8/3/65		
23C. PHYSICIAN'S NAME (Type) Robert Lee Jackson			23D. ADDRESS 600 N. Arlington Avenue		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/5/65		24C. NAME of CEMETERY or CREMATORY Carver Mem. Park	
24D. LOCATION Laurel, Maryland		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1965		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Arlington B. Phillips	
				ADDRESS 1727 N. Monroe Street	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				65 8079		Registered No. 65 8079	
BIRTH NO. 65 8079				GAY			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Myrtle Bussey		2. DATE AND HOUR OF DEATH 8/3/65 1 2 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital				A. STATE md		B. COUNTY 12-06	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto.			
				D. STREET ADDRESS (If rural, give location) 2633 N. Charles St.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH 6/22/95	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter French Bussey				14. MOTHER'S MAIDEN NAME Lena Turner			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-18-6122		17. INFORMANT ADDRESS Baltimore, Md. 21218 Blanche Marwitz 2633 N. Charles St.			
18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) Acute & chronic cong heart fail. DUE TO		1 wk	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Pulmonary carcinomatosis DUE TO		?	
				(C) Ca of Breast D.		?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic bronchitis & emphysema.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/16 19 65 to 8/3 19 65, that (I) (we) last saw the deceased alive on 8/3 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. Lee Robbins				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/3/65	
23C. PHYSICIAN'S NAME (Type) Mary Hosp				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-6-65		24C. NAME of CEMETERY or CREMATORY Fort Lincoln Cemetery		24D. LOCATION (City, town, or county) (State) Washington D.C.	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1965		25B. NAME OF REGISTRAR E. Lee Robbins		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc		ADDRESS Baltimore, Maryland	



BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **65 8080**

BIRTH NO. **65 8080**

M.E. CASE NO. **65 8080**

1. NAME OF DECEASED (Type or Print) **MILDRED LEE**

2. DATE AND HOUR PRONOUNCED DEAD **8-1-65 10:05 P.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD **JOHNS HOPKINS HOSPITAL - DOA**

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE **Virginia**

B. COUNTY **K-13**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Meherrin**

D. STREET ADDRESS (If rural, give location) **Rte. #1 - Box 9**

5. SEX **Female**

6. RACE **Colored**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) **Married**

8. DATE OF BIRTH **9-16-1914**

9. AGE (In years last birthday) **50**

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife**

10B. KIND OF BUSINESS OR INDUSTRY **own home**

11. BIRTHPLACE (State or foreign country) **Meherrin, Va**

12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **William P. Stokes**

14. MOTHER'S MAIDEN NAME **Mamie Neal**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service **NO**

16. SOCIAL SECURITY NO. **Howard Lee 2223 E. Chase St.**

17. INFORMANT ADDRESS

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Coronary occlusion with multiple myocardial infarcts

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **8-20-65**

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) **Yes**

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **Yes**

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. ☐ UNDERLYING ☐ CONTRIBUTING

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Peter W. Rieckert** M.D. CHIEF MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) **PETER W. RIECKERT, M.D.** ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☒ DATE SIGNED **8-2-65**

23A. BURIAL CREMATION, REMOVAL (Specify) **Removal**

23B. DATE **8-3-65**

23C. NAME OF CEMETERY or CREMATORY **Levi Baptist Ctry. Greenbay, Va.**

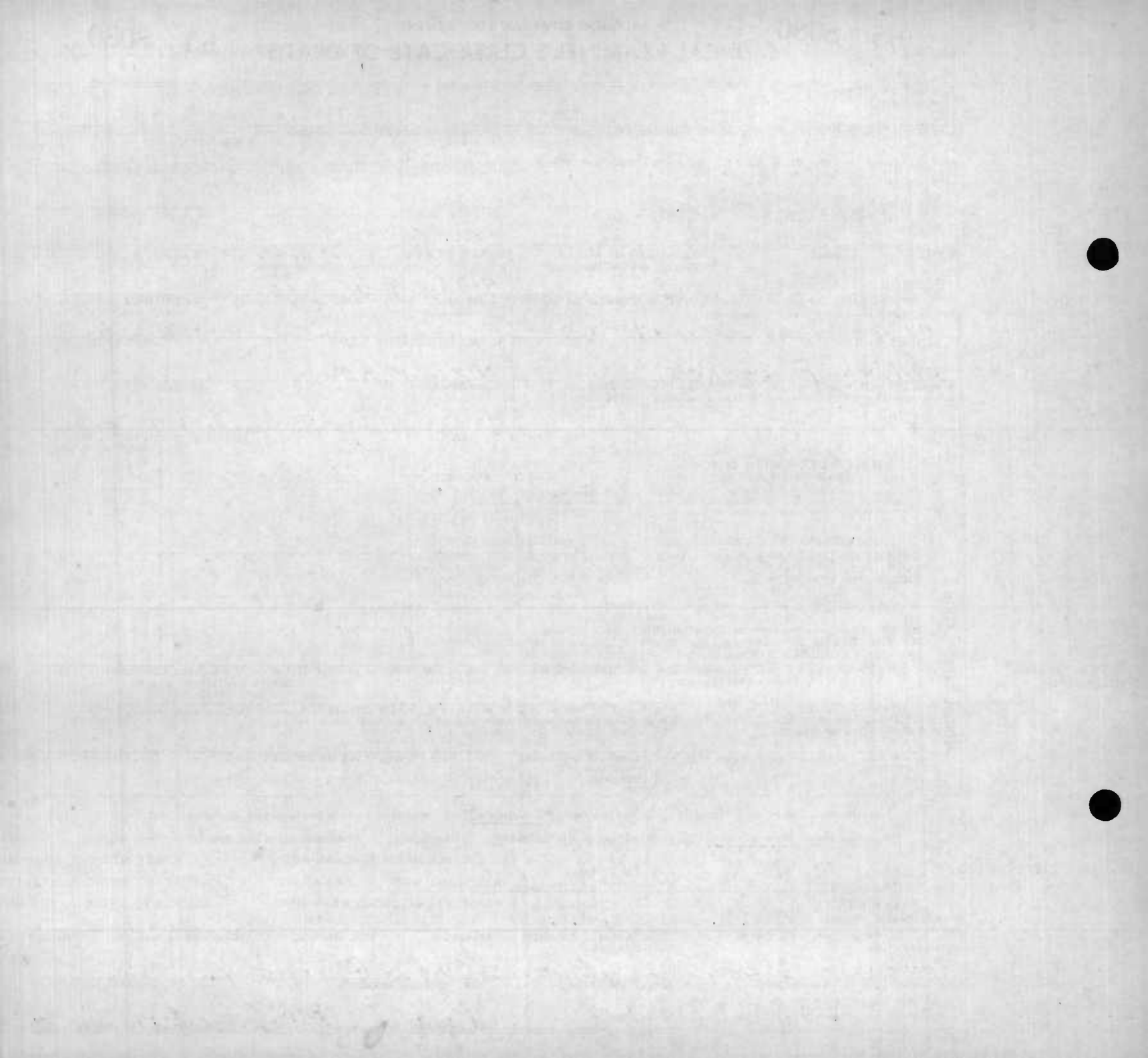
23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT. **AUG 4 1965**

24B. NAME OF REGISTRAR **Robert E. Faulkner**

24C. FUNERAL DIRECTOR **Randolph J. Collick**

24D. ADDRESS **1412 E. Preston St.**



CERTIFICATE OF DEATH

Registered No. 65 8081

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Sarah G. Waitsman

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1405 E. Fayette Street - #21231

5. SEX

6. RACE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.

Female

White

Widowed

12-25-93

71

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HUMANITARIAN

10B. KIND OF BUSINESS OR INDUSTRY

NONE

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

HYMAN GLAZER

14. MOTHER'S MAIDEN NAME

PAULINE GLAZER

??

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

217-26-0858 RECORDS-BCH-4940 Eastern Avenue-21224

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) Aspiration
DUE TO(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Diabetes - Uremia

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At
Work ☐Not While
At Work ☐22. I certify that (I) (this hospital) attended the deceased from 7-31-1965 to 7-31-1965,
that (I) (we) last saw the deceased alive on 7-31-1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7-31-65

23C. PHYSICIAN'S
NAME (Type)

Dr. J. Richmon

M.D.

23D. ADDRESS

BCH-4940 Eastern Avenue-Baltimore, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

8-3-65

UNITED HEBREW

ROSCDALE Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

AUG 4 1965

Robert E. Farber

JACK LEWIS INC. 2100 EUTAW PL.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

8/9/65 - Autopsy revealed
presence of drug
information received via phone from Dr. Richmond - BCH.
85.

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 8082 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 8082

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DORA KATZ

2. DATE AND HOUR PRONOUNCED DEAD

8/2/65 6:35 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4165 Fairview Ave.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

RUSSIA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

ABRAHAM

14. MOTHER'S MAIDEN NAME

Bessie Mamie

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

—

No

16. SOCIAL
SECURITY NO.

215-09-26560

17. INFORMANT

ADDRESS

5808

ALBERT JOSEPHWITZ 104 AVE

18.

4221

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/3/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/4/65

23C. NAME of CEMETERY or CREMATORY

Mt Carmel - BALTO. CITY

23D. LOCATION

(City, town, or county)

BALTO. CITY

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 4 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

JACK LEWIS - 2100 EIGHTH PL

ADDRESS

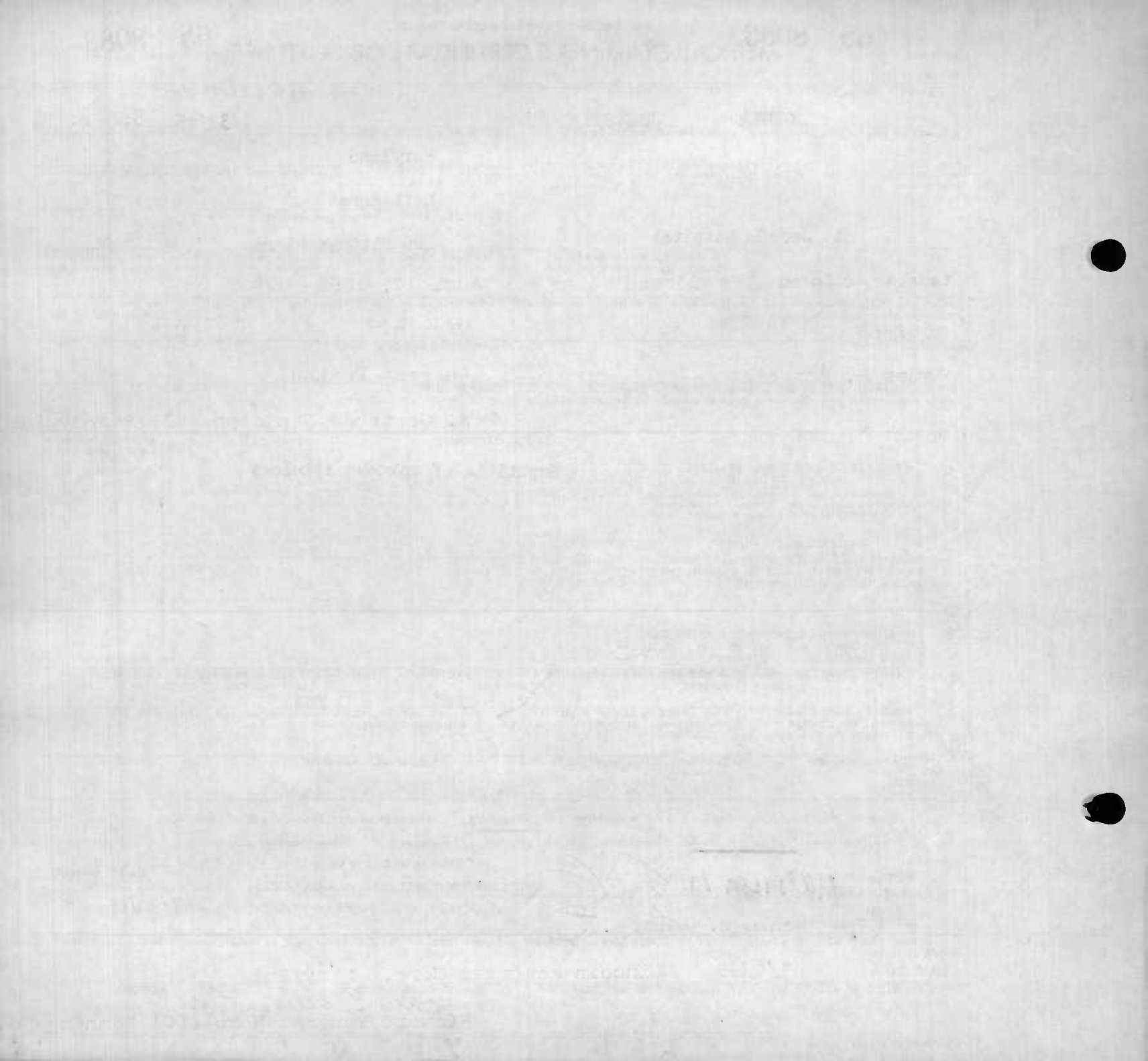
Small Court - 14.5.1940 - 14.5.1940 - 14.5.1940

WALTER BOWEN

WALTER BOWEN

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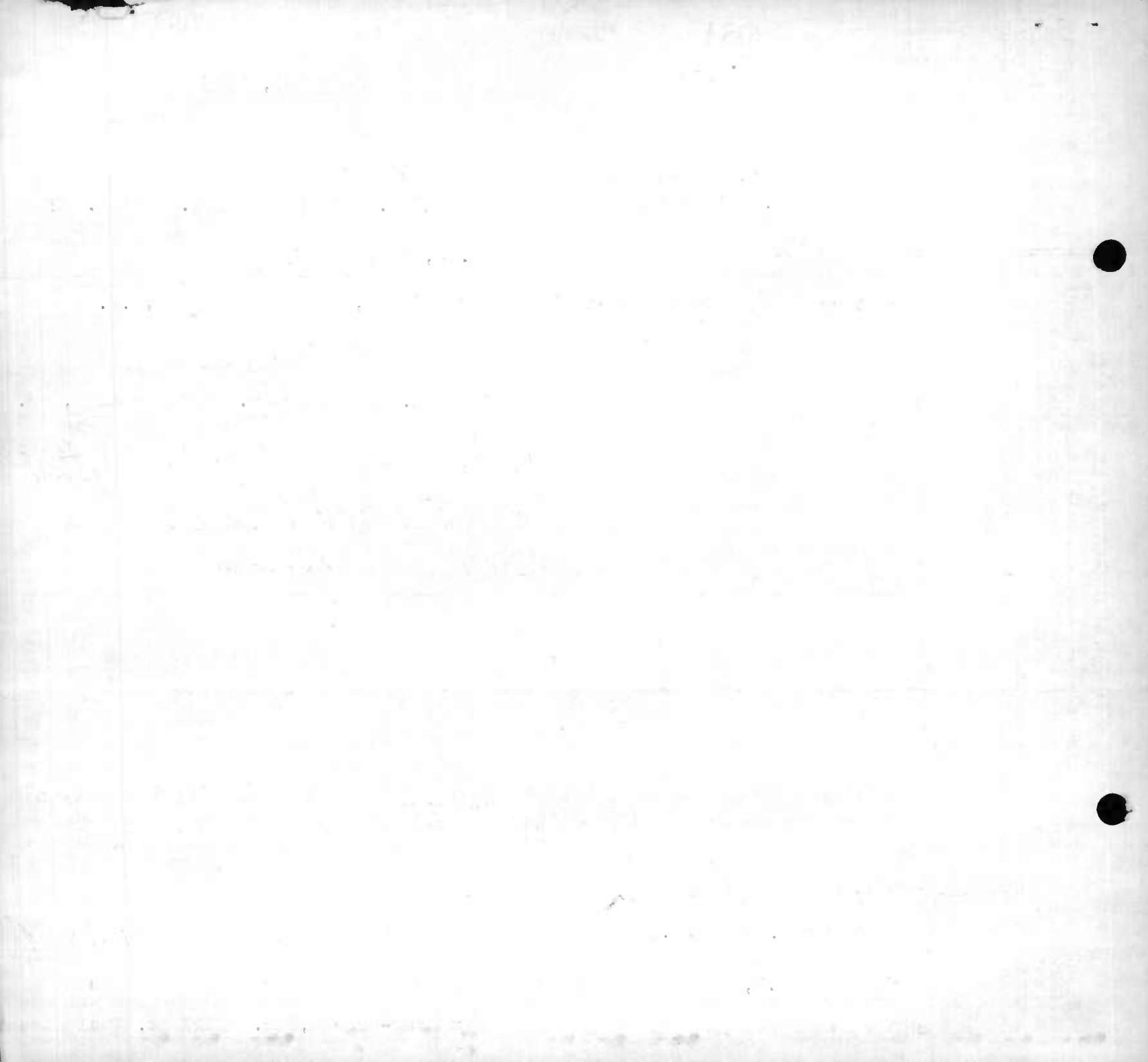
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
65 8083						65 8083	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD			
OENIA JOHNSON				7/30/65 8:25 a. m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Maryland			
St. Joseph Hospital				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 425 Pittman Place			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.		
female	colored	Widowed	Aug. 17, 1886	78			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired				Virginia		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
James A. Burrell				Lurrena Burton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
				Mrs. Gertrude Randolph 431 Brandywine			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Hepatitis of unknown etiology			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) DUE TO			
				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				yes		yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
Werner U. Spitz, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		7/30/65	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Burial		7/4/65		Lincoln Memorial Ceme.		Maryland	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS	
AUG 4 1965		Robert E. Faldut		John F. Stewart, Jr.		Stewart Funeral Home-4001 Benning Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8084				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8084	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Anne L. Cole		July 30, 1965 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
Broadview Apartments				Maryland		12-01	
116 W. University Parkway				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
				D. STREET ADDRESS (If rural, give location)		116 W. University Pkwy. Apt. 720	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
Female	White	Widow	Nov. 4, 1907	57			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Secretary		Isbrandtsen Lines		Baltimore, Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
(unknown) Larkins				Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				James M. Carpenter Jr.		Reisterstown, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		Acute Coronary Occlusion Instant	
ANTECEDENT CAUSES				(B) DUE TO		Rheumatic Heart disease	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO		Bronchial Asthma	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from March 1953 to 2 Aug 1965, that (I) (we) last saw the deceased alive on 19 July 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. Died 30 July 1965							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Joseph E. Muse Jr.							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Joseph E. Muse, Jr.,				2725 N. Charles St. Balt. 18, Md			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Aug. 3, 1965		Loudon Park Cemetery		Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 4 1965		Robert S. F. A. M. D.		Wm Cook-Brooks, Inc.		1217 St. Paul Street	



1
C-534

King George Co., Va.
65 8085

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 8085

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 8085

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
LARRY LEROY CHANDLER		8-1-65 1 7:35 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 12-06 D. STREET ADDRESS (If rural, give location) 2114 St. Paul Street	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH Sep 12, 1963
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 22 mos
13. FATHER'S NAME Donald Chandler		11. BIRTHPLACE (State or foreign country) King George Co. Va.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. None		14. MOTHER'S MAIDEN NAME Lillian Thomas	
17. INFORMANT Lillian Thomas		ADDRESS 2114 St. Paul St. Balt. Md.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E 902.10 ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21C. WHERE DID INJURY OCCUR? 2114 St. Paul Street 12-06		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) 8 1 '65 5:28 PM	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell from 3rd floor window	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) PETER W. RIECKERT, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL Removal		23B. DATE 8-3-65	23C. NAME OF CEMETERY or CREMATORY Family Plot King George Co Virginia
23D. LOCATION (City, town, or county) (State) King George Co., Virginia		24A. DATE REC'D BY HEALTH DEPT. AUG 4 1965	
24B. NAME OF REGISTRAR Robert E. Fairbank		24C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc 1217 St. Paul St. Balt. Md.	

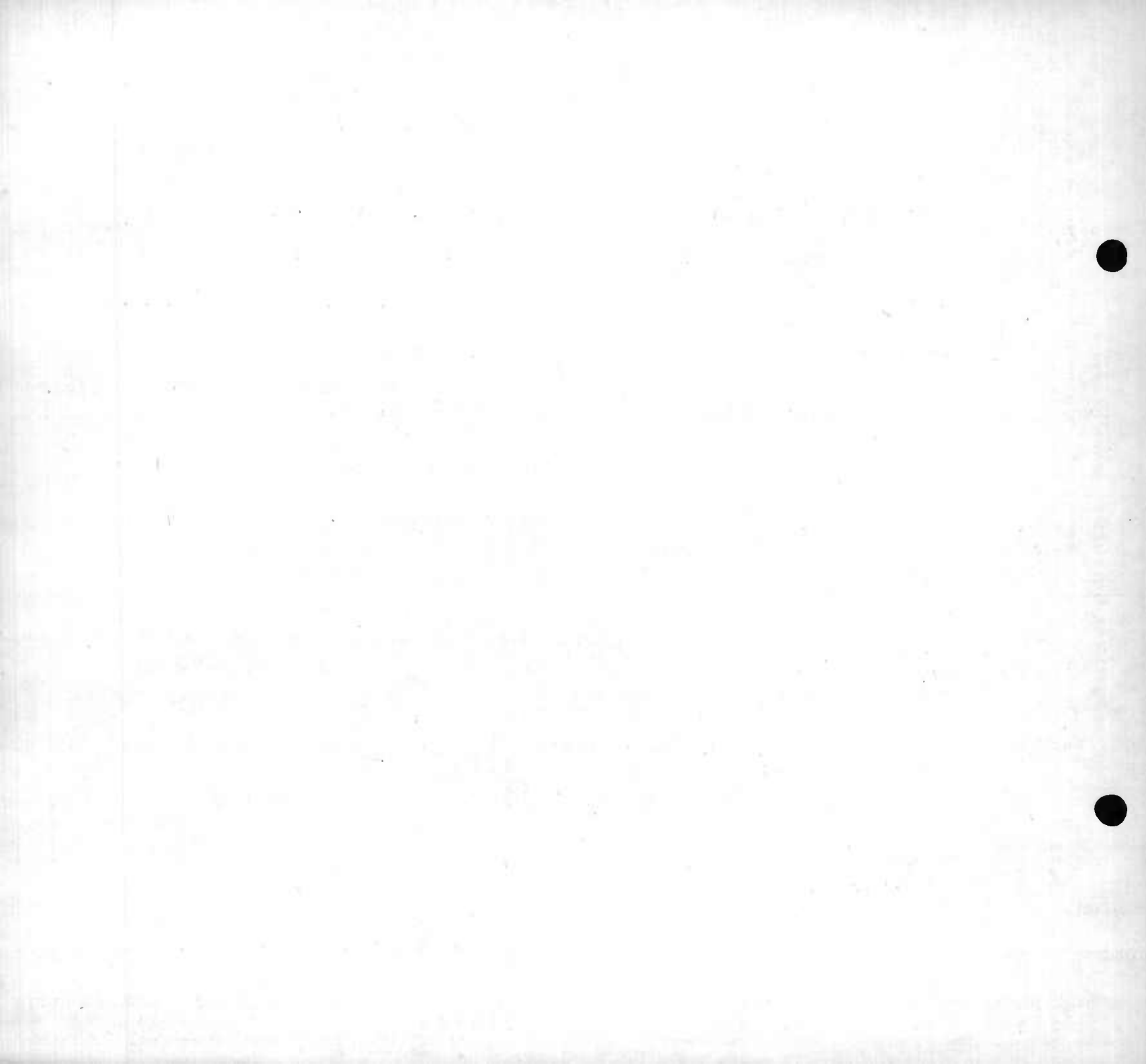
VS 151-REV. 1/1/65

VALLEY FORT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8086	
BIRTH NO. 65 8086		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HUGHES, James (NMI)		2. DATE AND HOUR OF DEATH 8/3/65 11:25 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		A. STATE Maryland B. COUNTY 8-03			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 2619 E. Chase Street			
5. SEX Male	6. RACE Negroid	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 12/14/93	9. AGE (In years lost birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Hughes		14. MOTHER'S MAIDEN NAME Emma Banks	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 6/21/18 2/27/19		16. SOCIAL SECURITY NO. 217 07 7940		17. INFORMANT ADDRESS VA Hospital Records 3900 Loch Raven Blvd. Baltimore, Maryland 21218	
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) Pulmonary Hemorrhage DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 Hour			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Bronchogenic Carcinoma DUE TO		7 Months	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Arteriosclerotic Cardiovascular Disease		Years	
19A. DATE OF OPERATION O	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/64 19 64 to 8/3/ 19 65 , that (I) (we) last saw the deceased alive on 8/3/ 19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert Hamilton		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/3/65	
23C. PHYSICIAN'S NAME (Type) Robert Hamilton		23D. ADDRESS VA Hospital, 3900 Loch Raven Boulevard Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-9-1965	24C. NAME of CEMETERY or CREMATORY Baltimore Cat	24D. LOCATION (City, town, or county) (State) Baltimore Md		
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1965	25B. NAME OF REGISTRAR Robert E. Farkner	25C. FUNERAL DIRECTOR ADDRESS Lafayette A. Wilson 1001 Brantly Ave			




FUNERAL DIRECTOR: IMPORTANT

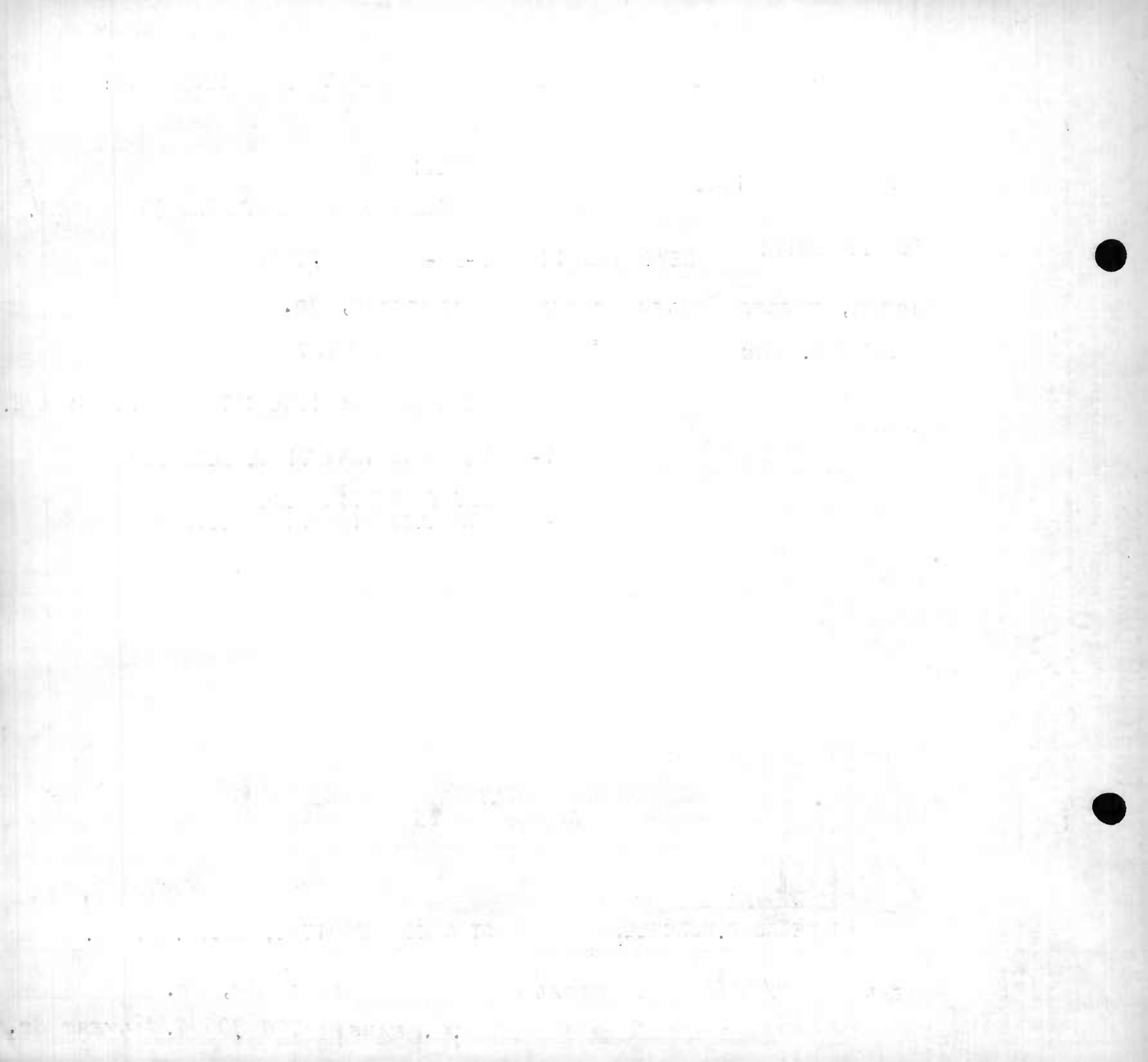
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>65 8087</u>				BALTIMORE CITY DEPARTMENT		CERTIFICATE OF DEATH		Registered No. <u>65 8087</u>	
1. NAME OF DECEASED (Type or Print) <u>Estelle F. Ennis</u>				2. DATE AND HOUR OF DEATH <u>July 30, 1965</u> <u>5:15 P.M.</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland #21224</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>16-05</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>708 Whitmore Avenue #21216</u>					
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2-21-88</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Henry Duke</u>			14. MOTHER'S MAIDEN NAME <u>Edith Tabbs</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS <u>RECORDS: BCH: 4940 Eastern Avenue</u>			
18. <u>153.8 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Carcinoma of Colon</u> DUE TO (B) _____ DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH <u>1 3/4 Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Urinary Tract Infection</u>									
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>February 16, 1965</u> to <u>July 30, 1965</u> , that (I) (we) last saw the deceased alive on <u>July 30, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>J. B. Zachary</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>July 30, 1965</u>					
23C. PHYSICIAN'S NAME (Type) <u>Dr. J. B. Zachary</u>				23D. ADDRESS M.D. <u>4940 Eastern Avenue Baltimore, Md.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/4/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>3501 Frederick Ave Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 4 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Joseph L. Russ</u> ADDRESS <u>2222 N. North Ave (U6)</u>					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8088	
BIRTH NO. 65 8088		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BERG HELEN E		2. DATE AND HOUR OF DEATH AUGUST 3 1965 10:40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 28-04			
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	
8. DATE OF BIRTH 7-31-86		9. AGE (In years lost birthday) 78 79		10. CITIZEN OF WHAT COUNTRY? HOME 2 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER, RETIRED		10B. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOL		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
13. FATHER'S NAME ALBERT C. BERG		14. MOTHER'S MAIDEN NAME MARY CONRY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE.	
18. 6740.0 + 260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH 1-ACUTE GASTROINTESTINAL BLEEDING (A) DUE TO SECONDARY TO PEPTIC ULCER (B) DUE TO 2-UNCONTROLLED DIABETES MELLITUS (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JULY 27 1965 to AUG 3 1965 , that (I) (we) last saw the deceased alive on AUG 3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 3, 1965	
23C. PHYSICIAN'S NAME (Type) PEDRO P. PURCELL		23D. ADDRESS M.D. ST AGNES HOSPITAL, BALTO. 29, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/7/65		24C. NAME of CEMETERY or CREMATORY CATHEDRAL	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.		25A. DATE REC'D BY HEALTH DEPT. AUG 5 1965			
25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS H.W. MEARS & SON 805 N. CALVERT ST.			



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FRANK WANKEN

2. DATE AND HOUR PRONOUNCED DEAD

8-1-65

5:05 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1009 E. 43rd Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Never married

8. DATE OF BIRTH

8,28,1894

9. AGE (in years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

Auto

11. BIRTHPLACE (State or foreign country)

Baltimore, M d.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George

14. MOTHER'S MAIDEN NAME

Kirshner

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.
212,03,1531

17. INFORMANT

ADDRESS

Henry Wanken, 1009 E. 43rd. St., Baltimore, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cerebral vascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

PETER W. RIECKERT, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

8-2-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8,4,1965

23C. NAME of CEMETERY or CREMATORY

Govens Presbyterian

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 5

1965

Robert E. F. Adams

Wm. Cook-Brooks Towson

1050 York Rd. 4

VALLEY FORGE

1793

General

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8090		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8090	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HAROLD BRAUN		2. DATE AND HOUR OF DEATH August 2, 1965 11:55 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 1-02			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 617 S. LINWOOD AVE.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.			
		D. STREET ADDRESS (If rural, give location) 617 S. LINWOOD AVE.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8/22/06	9. AGE (In years lost birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) VIOLIBROS. SHEET METAL		10B. KIND OF BUSINESS OR INDUSTRY NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DECEASED		14. MOTHER'S MAIDEN NAME DECEASED			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-01-4499		17. INFORMANT ADDRESS MRS. LOTTIE BRAUN 617 S. LINWOOD AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.11Y260X		CAUSE OF DEATH (A) Acute Myocardial Infarction DUE TO Arteriosclerotic Cardio-vascular Disease (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 5 yrs. 1 1/2 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Diabetes Mellitus			
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 20 19 63 to Aug. 2 19 65, that (I) (we) last saw the deceased alive on June 9 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Clarence W. LeDoux		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/3/65	
23C. PHYSICIAN'S NAME (Type) Clarence W. LeDoux		23D. ADDRESS 3023 Eastern Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/6/65		24C. NAME OF CEMETERY or CREMATORY MORELAND MEMORIAL	
				24D. LOCATION (City, town, or county) (State) BALTO. Co. MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR ADDRESS 3218 HUDSON ST. 24	

BIRTH NO.

65 8091

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 8091

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARK

TIPTON

2. DATE AND HOUR PRONOUNCED DEAD

July 31, 1965

10:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2210 E. Baltimore Street

5. SEX

Male

6. RACE

Caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

July 31, 1965

9. AGE (In years
lost birthday)

1

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

6

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Larry Tipton

14. MOTHER'S MAIDEN NAME

Cleo Lucinda Menge

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Larry Tipton

2210 E. Baltimore St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Acute Pneumonitis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Ingestion of Furniture Polish.
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

2210 E. Baltimore Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
7 28 '65 P

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Drank furniture polish.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/1/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Aug. 3, 1965

23C. NAME of CEMETERY or CREMATORY

Cedar Hill Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

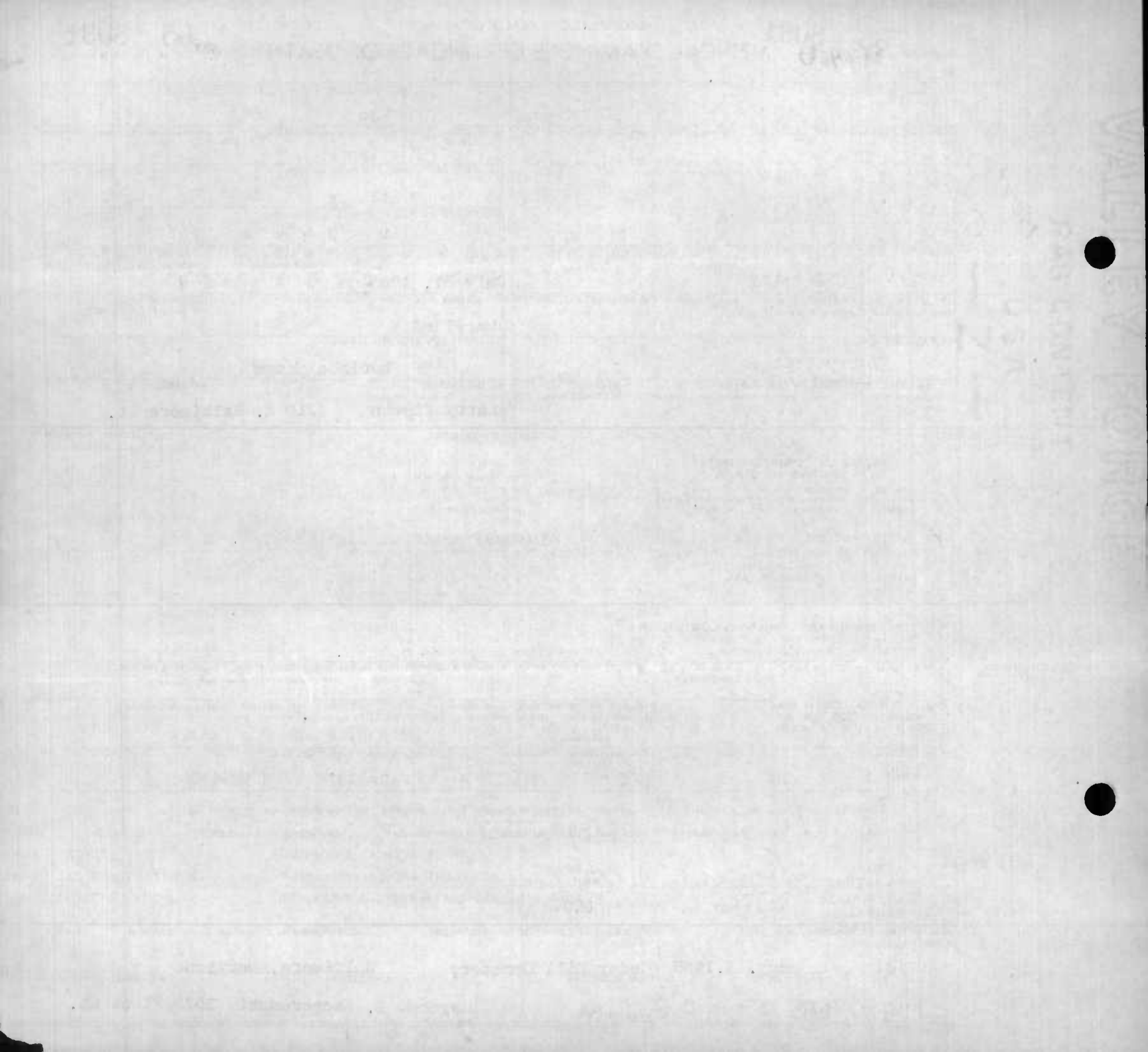
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 5 1965

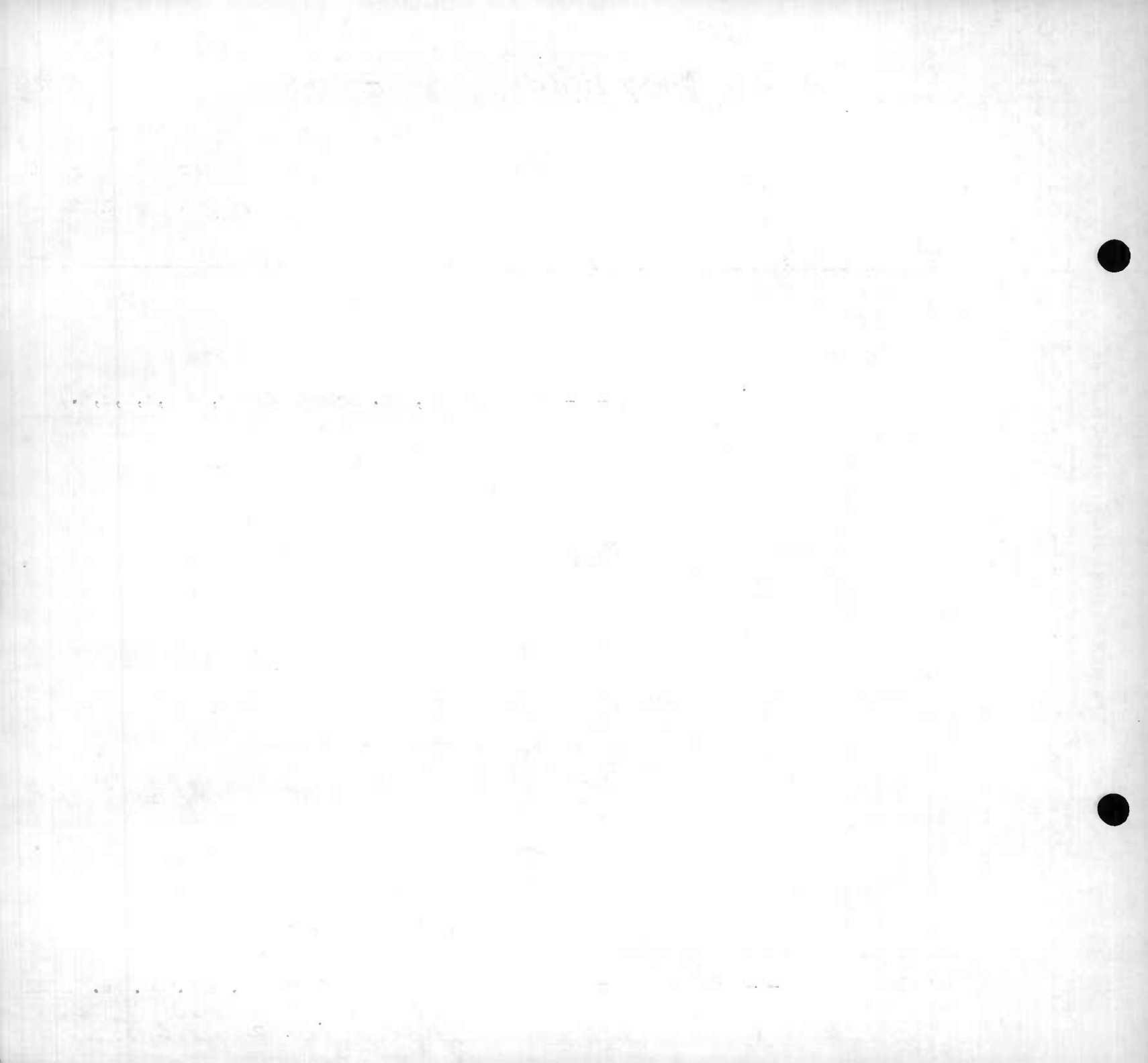
Raymond L. Kaczorowski 2525 Fleet St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

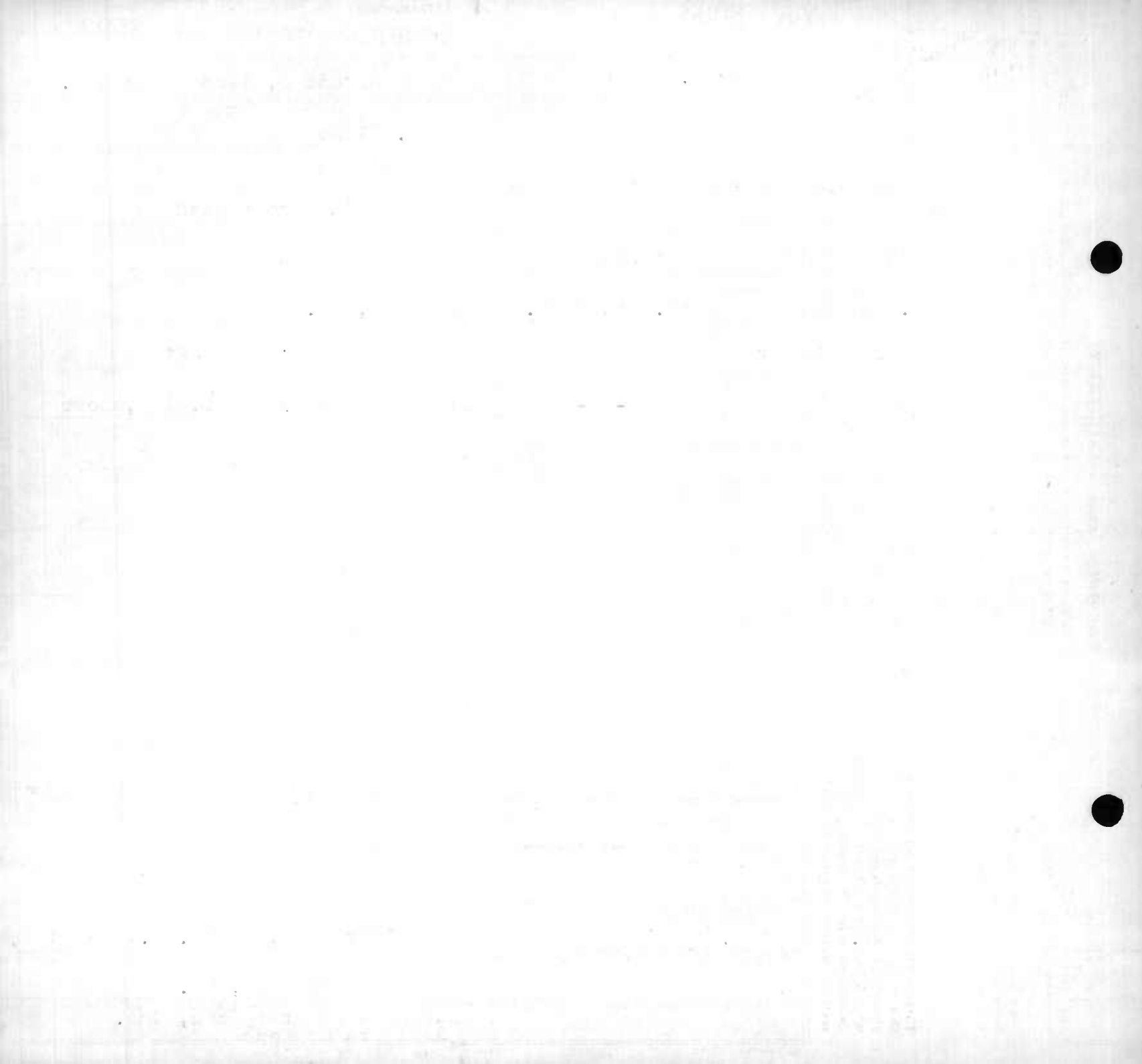
BIRTH NO. 65 8092				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8092	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Miller, Mary Helen</i>				2. DATE AND HOUR OF DEATH <i>8-2-65 1:35 AM</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE <i>Maryland</i>		B. COUNTY <i>Baltimore</i>	
<i>Franklin Square Hospital</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		<i>Dundalk 5300</i>	
				D. STREET ADDRESS (If rural, give location) <i>8616 Wise Ave</i>		<i>21222</i>	
5. SEX <i>F</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>10-24-87</i>	9. AGE (In years last birthday) <i>77</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>*****</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Adams ?</i>				14. MOTHER'S MAIDEN NAME <i>?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>118-12-7639</i>		17. INFORMANT ADDRESS <i>Husband, Mr. Ernest Miller, # 4, a, b, c, d.</i>			
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO <i>Congestive Heart Failure</i>			
ANTECEDENT CAUSES				(B) DUE TO <i>Myocardial Infarction</i>		<i>5 days</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>7/26</i> 19 <i>65</i> to <i>8/2</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>8/2</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>John J. Quota</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8/2/65</i>	
23C. PHYSICIAN'S NAME (Type) _____				23D. ADDRESS <i>Franklin Square Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-5-1965</i>		24C. NAME of CEMETERY or CREMATORY <i>Oak Lawn</i>		24D. LOCATION (City, town, or county) (State) <i>Eastern Ave. Bal. CO. Md. 21222</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 5 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Faldut</i>		25C. FUNERAL DIRECTOR <i>John J. Quota</i> ADDRESS <i>7922 Wise Ave Balto 22, Md.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

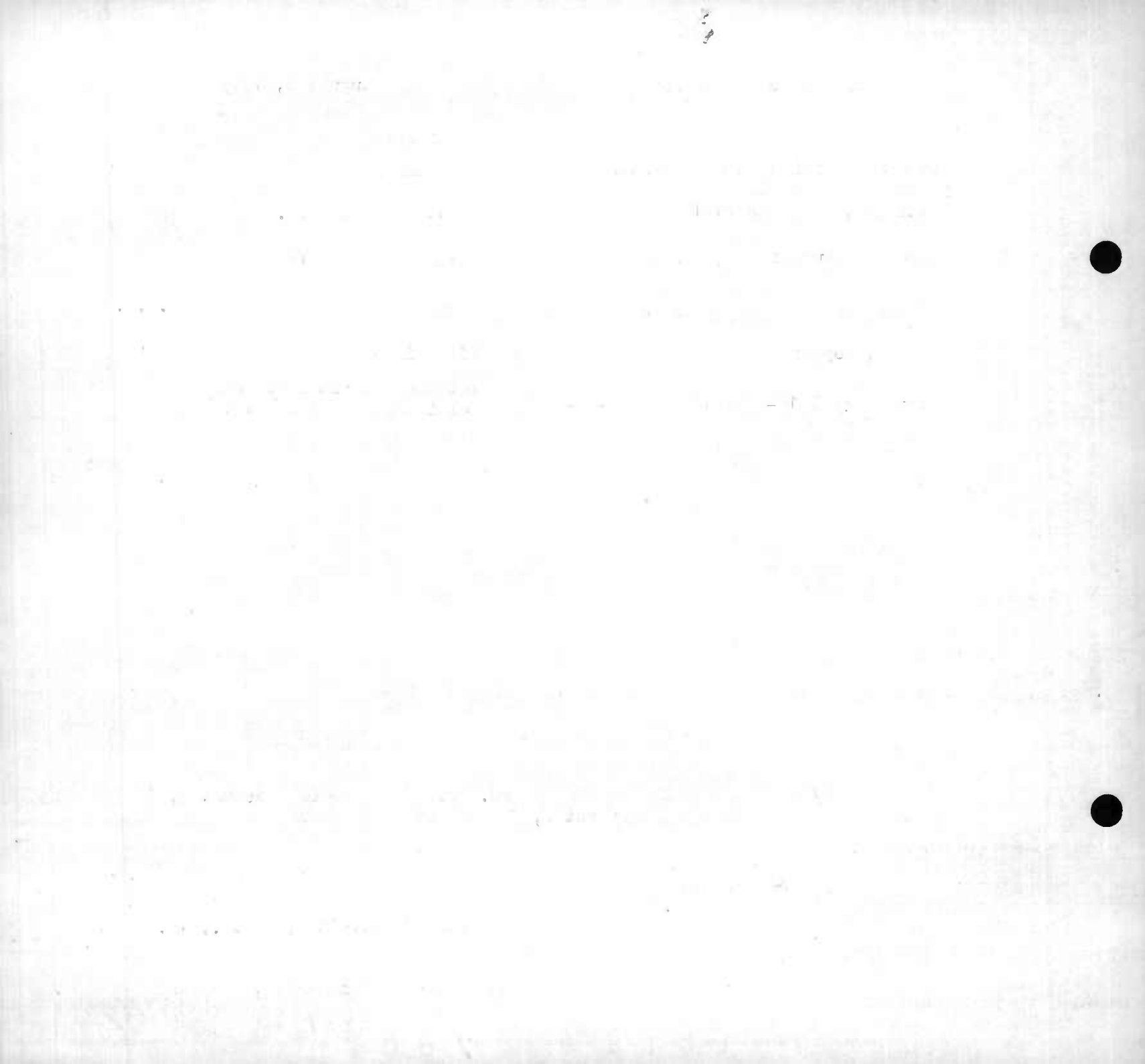
BIRTH NO. 65 8093		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 8093	
1. NAME OF DECEASED (Type or Print) HENRY A. SPOHR			2. DATE AND HOUR OF DEATH August 3, 1965 4:30 p. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital (DOA)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. 21206 B. COUNTY 27-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4008 Ridgcroft Road		
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 12/27/1908	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen. Foreman		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME John Spohr			14. MOTHER'S MAIDEN NAME Mary Catherine Kraft		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-10-2102		17. INFORMANT ADDRESS Catherine Watsic Spohr, wife, above	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction			INTERVAL BETWEEN ONSET AND DEATH 5 minutes		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			(A) DUE TO (B) DUE TO (C) DUE TO		
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Epilepsy			Life.		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 6/22/1962 to 8/3/1965 , that (I) (we) last saw the deceased alive on 8/3/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Albert B. Bradley 23C. PHYSICIAN'S NAME (Type) Dr. Albert B. Bradley				23B. DATE SIGNED 8/3/1965	
23D. ADDRESS 4900 Belair Road, Balto. Md., 21206		24. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 8/7/65		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1965		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8094	
BIRTH NO. 65 8094		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Boyden, Donald Galloway		2. DATE AND HOUR OF DEATH August 2, 1965 2:00 Am.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-11		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218		D. STREET ADDRESS (If rural, give location) 5112 Norwood Ave.			
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 8/19/92	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10B. KIND OF BUSINESS OR INDUSTRY Black & Decker		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George, Boyden		14. MOTHER'S MAIDEN NAME Virginia Galloway	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 4/27/18-6/25/19		16. SOCIAL SECURITY NO. 212-10-9531A		17. INFORMANT ADDRESS Veterans Hospital Records Baltimore, Maryland 21218	
18. 180X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH CARCINOMA of the KIDNEY with METASTASES		INTERVAL BETWEEN ONSET AND DEATH 3 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (✓) (this hospital) attended the deceased from Dec. 30, 19 64 to August 2, 19 65 , that (X) (we) last saw the deceased alive on August 2, 19 65 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. H. Twining				23B. DATE SIGNED 8/2/65	
23C. PHYSICIAN'S NAME (Type) RALPH H. TWINING		23D. ADDRESS Veterans Hospital, Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/5/1965		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 5 1965		25B. NAME OF REGISTRAR Robert E. Fairbank	
25C. FUNERAL DIRECTOR Glen Seitz Funeral Home		25D. ADDRESS 7609			



FUNERAL DIRECTOR: IMPORTANT

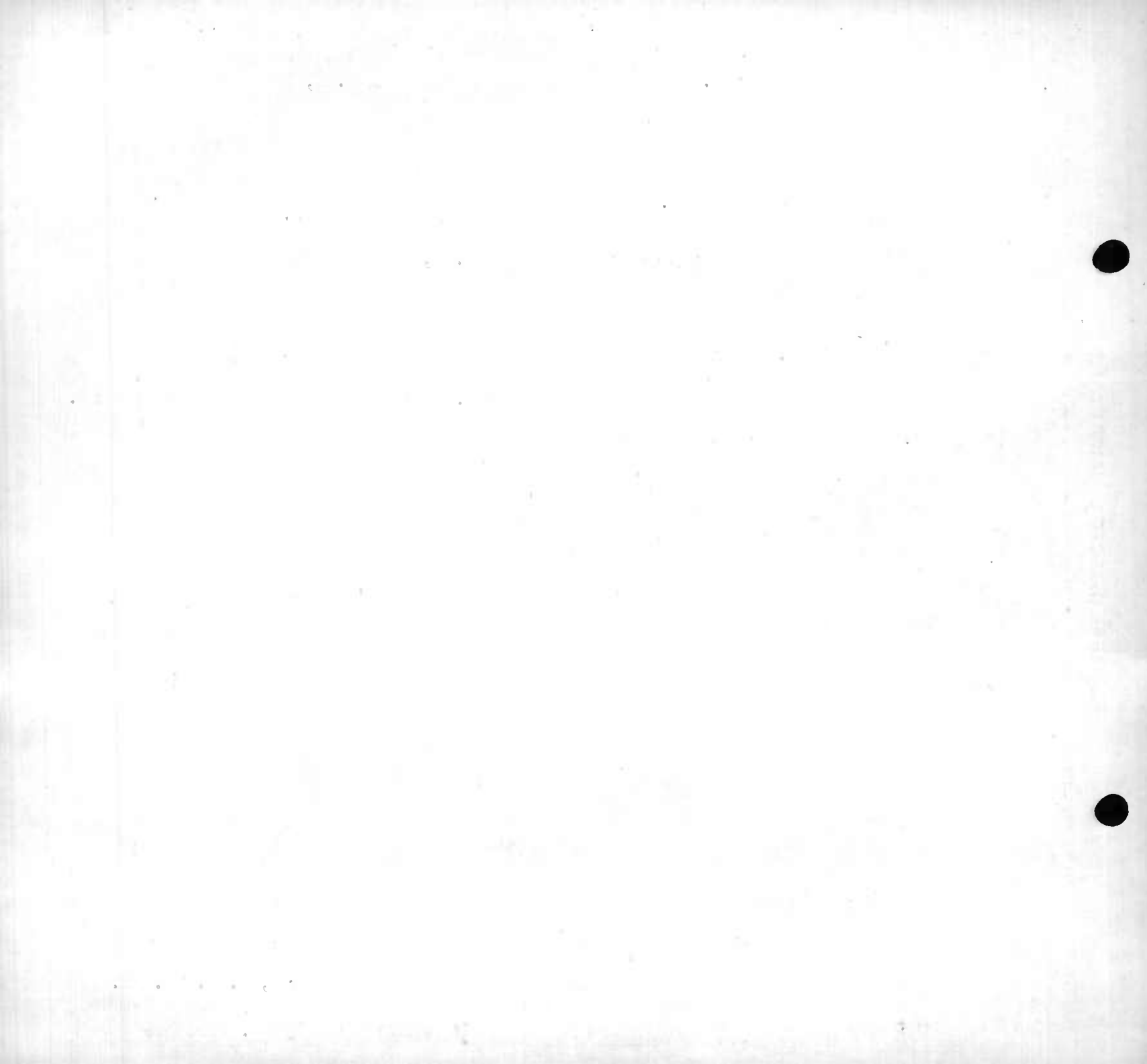
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8095				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8095	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Archibald Rennie</i>				2. DATE AND HOUR OF DEATH <i>8/3/65 110:15 P. M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE <i>Maryland</i>		B. COUNTY <i>24-04</i>	
<i>South Balto. Gen. Hosp.</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location) <i>119 E. Fort Ave</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>12 31 1887</i>	9. AGE (In years last birthday) <i>77</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cutter</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Clothing</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>John Rennie</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Fernan</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215 01 8591</i>		17. INFORMANT <i>Mrs. Bertha M. Rennie</i>		ADDRESS <i>119 E. Fort Ave.</i>	
18. <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <i>Congestive Heart Failure</i> (A) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Arteriosclerotic Cardiovascular Disease</i> (B) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>7/13/65</i> to <i>8/3/65</i> , that (I) (we) last saw the deceased alive on <i>8/3/65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>C. E. Jones, Jr.</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8/4/65 12:30 AM</i>	
23C. PHYSICIAN'S NAME (Type) <i>C. E. Jones, Jr.</i>				23D. ADDRESS <i>1213 Light St. Balti. Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8 7 1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>Glen Haven</i>		24D. LOCATION (City, town, or county) (State) <i>Glen Burnie, A. A. Co. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 5 1965</i>		25B. NAME OF REGISTRAR <i>Edith G. Taylor</i>		25C. FUNERAL DIRECTOR <i>Mc Cully</i>		ADDRESS <i>130 E. Fort Ave.</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

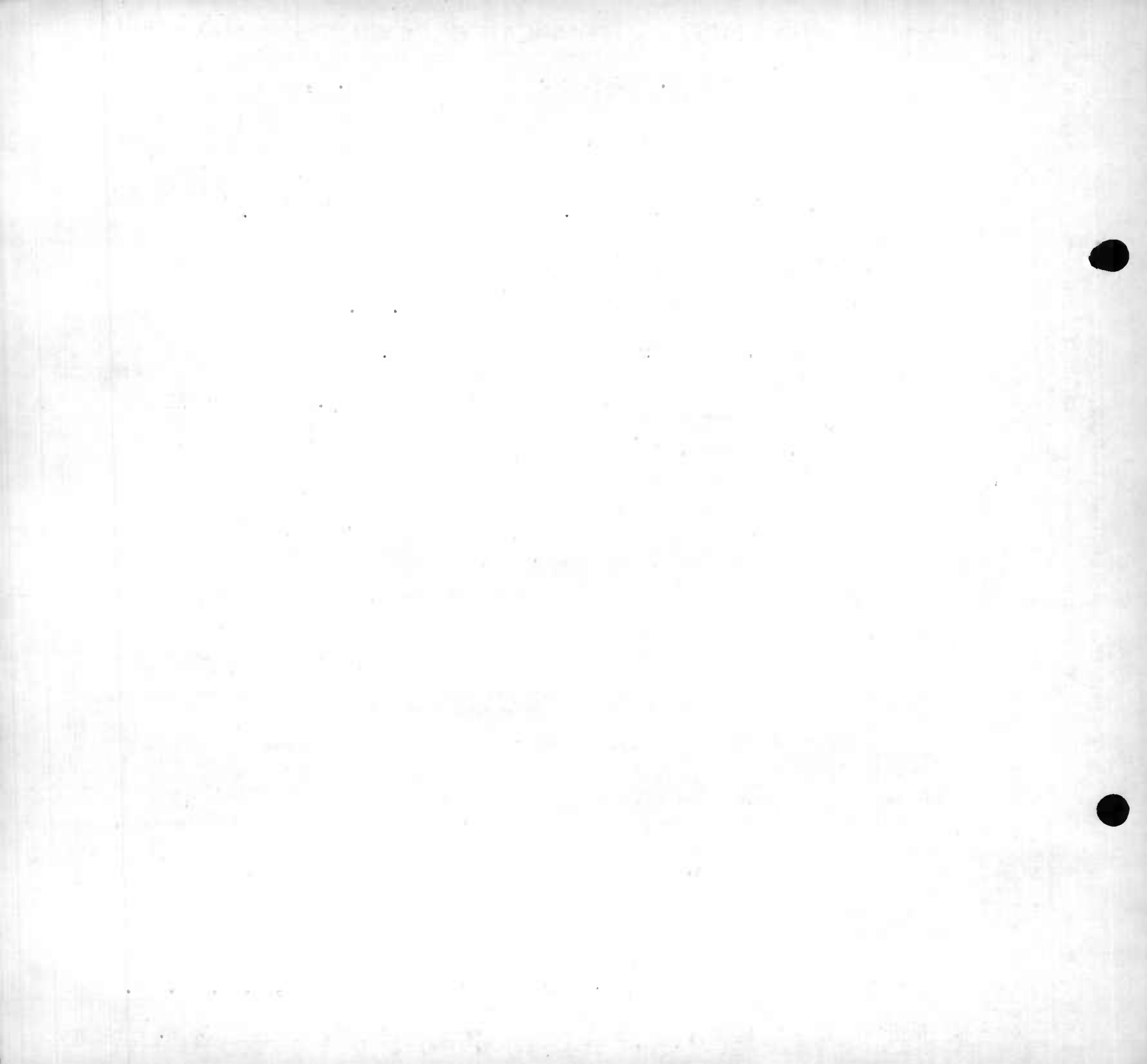
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8096	
BIRTH NO. 65 8096		CERTIFICATE OF DEATH			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Bessie C. Brannan		2. DATE AND HOUR OF DEATH Aug. 2, 1965 3:30 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1136 Patapsco St.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 23-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1136 Patapsco St.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH Nov. 7, 1892	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A			13. FATHER'S NAME David V. Allen		
14. MOTHER'S MAIDEN NAME Cordelia Wolford			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Elaine Lucas ADDRESS 1136 Patapsco St.		
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 45%;"> INTERVAL BETWEEN ONSET AND DEATH (A) DUE TO Coronary Artery Disease (B) DUE TO Arterio Sclerotic Heart Disease (C) _____ </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 8/20/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/15/65 19 to 8/2/65 19 that (I) (we) last saw the deceased alive on 7/27/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H.P. Friedman				23B. DATE SIGNED 8/2/65	
23C. PHYSICIAN'S NAME (Type) H.P. FRIEDMAN				23D. ADDRESS 1319 LIGHT ST. - BALTIMORE MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8 5 65		24C. NAME OF CEMETERY or CREMATORY Cedar Hill	
24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 5 1965			
25B. NAME OF REGISTRAR R. E. Faldut		25C. FUNERAL DIRECTOR Mc Gully ADDRESS 130 E. Fort Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8097	
BIRTH NO. 65 8097		CERTIFICATE OF DEATH			
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) George C. Pfisterer			Aug. 2, 1965 1 12:20 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1102 Riverside Ave.			A. STATE Maryland B. COUNTY 24-03		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 1102 Riverside Ave.		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 11 15 1900	9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Sea Food	11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Albert A. Pfisterer			14. MOTHER'S MAIDEN NAME Emma E. Sites		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Miss Gertrude E. Pfisterer 1102 Riverside Av		
18. 163 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma, lung ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinitely medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from July 1965 to Aug 2 1965 , that (I) (we) has saw the deceased alive on 8 Aug 1965 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ricardo Lozada				23B. DATE SIGNED 8/2/65	
23C. PHYSICIAN'S NAME (Type) RICARDO LOZADA				23D. ADDRESS M.D. 1228 S. Charles St. Balto 30 Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8 5 65		24C. NAME OF CEMETERY or CREMATORY Holy Cross	
24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR ADDRESS Mc Gully 130 E. Fort Ave	



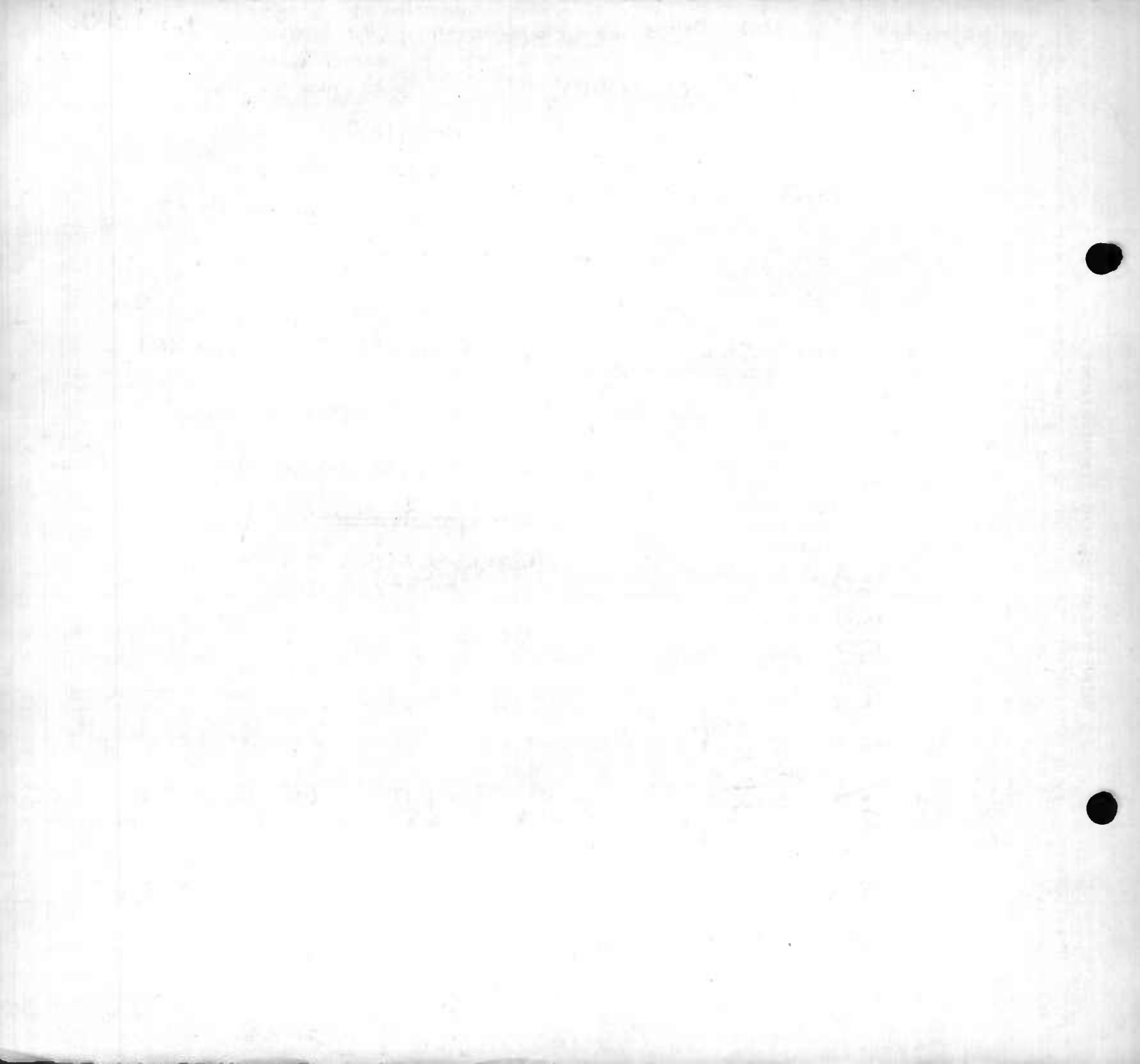
BIRTH NO. 65 8098		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8098	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					
M.E. CASE NO.			2. DATE AND HOUR PRONOUNCED DEAD		
1. NAME OF DECEASED (Type or Print) JAMES MCGOWAN			8/3/65 9:05 a. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)			A. STATE Md B. COUNTY		
1200 Stockton St.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 13-03		
D. STREET ADDRESS (If rural, give location) 2660 Flora St					
5. SEX male	6. RACE colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH April 24/1919	9. AGE (In years last birthday) 46	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
11. BIRTHPLACE (State or foreign country) Md			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Robert Mc Gowan			14. MOTHER'S MAIDEN NAME Mary Miller		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Mary Brooks			ADDRESS 2660 Flora St		
18. 00211 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH Pulmonary Tuberculosis Lobar pneumonia		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Fatty liver		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.			CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER		
23A. BURIAL CREMATION, REMOVAL (Specify) Burial			23B. DATE 8/6/65		
23C. NAME OF CEMETERY or CREMATORY Balto Nat'l			23D. LOCATION (City, town, or county) Balto Md		
24A. DATE REC'D BY HEALTH DEPT. AUG 5 1965			24B. NAME OF REGISTRAR Robert E. Taylor		
24C. FUNERAL DIRECTOR			ADDRESS 726 W. 1st Kilson 1348 N. Calhoun		

CHURCH
VALLEY FORGE
MENDED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

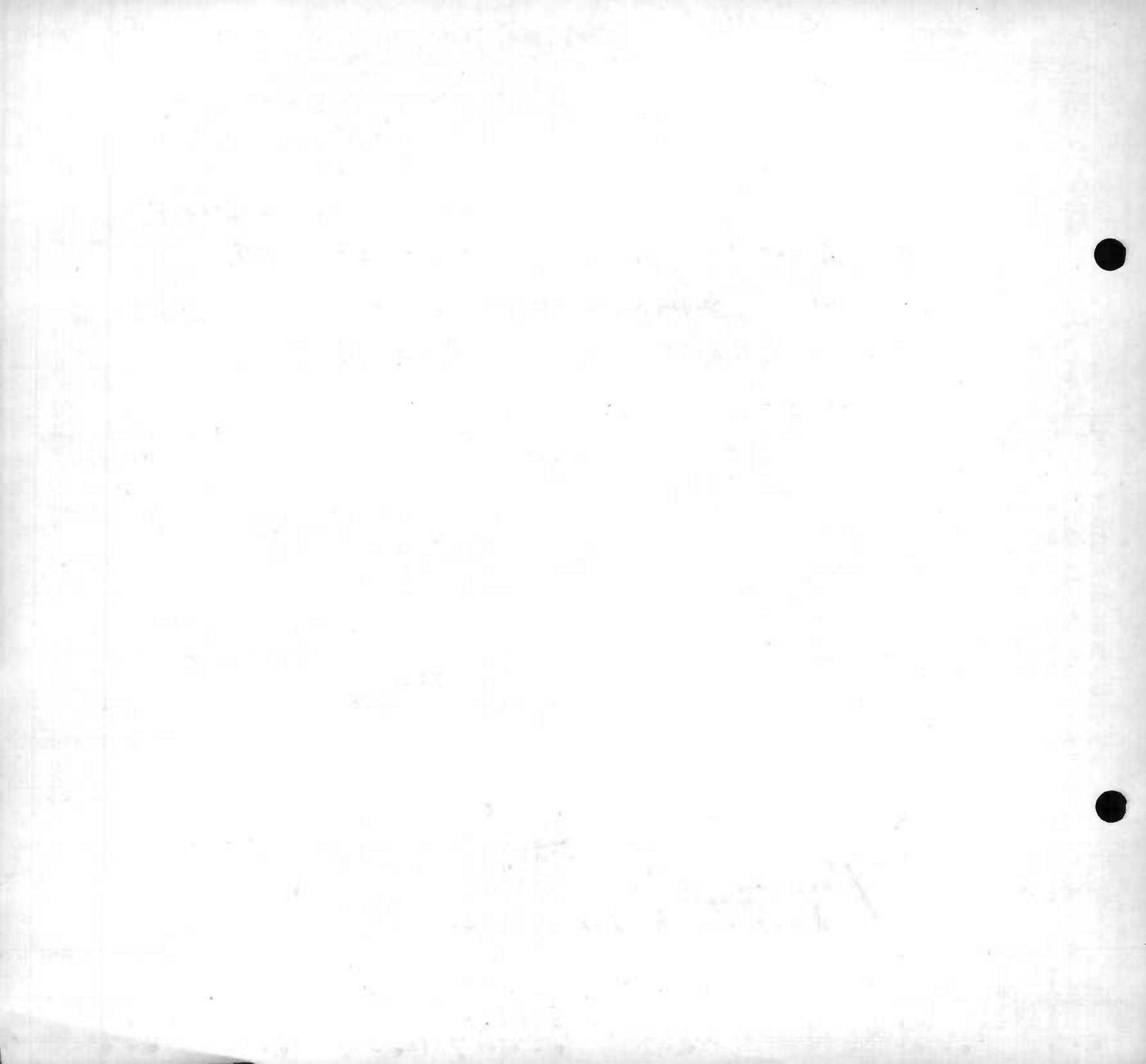
BIRTH NO. 65 8099		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 265-88008	
1. NAME OF DECEASED (Type or Print) SLEBZAK ROSEMARY			2. DATE AND HOUR OF DEATH August 3, 1965 2:15 AM.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL BALTIMORE 1, MARYLAND.			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27 33-00		
			D. STREET ADDRESS (If rural, give location) 2814 TENNESSE AVE.		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3/12/13	9. AGE (In years last birthday) 52	(If Under 1 Yr. Months: Days: Hours: Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JAMES JANKOWSKI.			14. MOTHER'S MAIDEN NAME FRANCES JARZYANSKI		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS JAMES SLEBZAK		
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIO-SCLEROTIC CORONARY ARTERY DISEASE.			CAUSE OF DEATH (A) DUE TO (B) GO HYPERTENSION (C) ARTERIO-SCLEROTIC CORONARY ARTERY DISEASE.		
INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE.					
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NONE		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) NONE		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>July 17</u> 19 <u>65</u> to <u>August 3</u> 19 <u>65</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>August 3</u> 19 <u>65</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE Fred R. Eilber.				23B. DATE SIGNED 8/3/65	
23C. PHYSICIAN'S NAME (Type) Fred R. Eilber				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) 8-6-65 HOLY ROSARY		24B. DATE		24C. NAME OF CEMETERY or CREMATORY BALTIMORE	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. AUG 5 1965			
25B. NAME OF REGISTRAR Robert E. Farkes, M.D.		25C. FUNERAL DIRECTOR Fred W. Ozazewski		25D. ADDRESS 1930 Eastern A	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8100		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8100	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) Williams George A		
2. DATE AND HOUR OF DEATH 8/3/65 5:55 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hosp.			A. STATE 8. COUNTY Maryland 20-04		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 2507 W. Balto Street		
5. SEX M	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 1-28-1933	9. AGE (In years last birthday) 32	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Strippy Moving & Storage		11. BIRTHPLACE (State or foreign country) Baltimore MD	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Williams			14. MOTHER'S MAIDEN NAME Elsie McCall		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 9-4-51 - 9-9-54		16. SOCIAL SECURITY NO. 215-28-1004	17. INFORMANT ADDRESS James Williams 41 N. BENTLEY ST		
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH (A) JAUNDICE DUE TO		INTERVAL BETWEEN ONSET AND DEATH 10 days
ANTECEDENT CAUSES (B) ACUTE FATTY LIVER (C) ASPIRATION PNEUMONIA					10 days
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					3 days
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (N) (this hospital) attended the deceased from August 1 1965 to August 3 1965, that (N) (we) last saw the deceased alive on August 3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (N) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alexander R. Lim M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED August 3, 1965	
23C. PHYSICIAN'S NAME (Type) Alexander R. Lim M.D.				23D. ADDRESS Bon Secours Hosp. Balto. 23	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/6/65	24C. NAME OF CEMETERY OR CREMATORY Balto National	24D. LOCATION (City, town, or county) (State) Balto Md		
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1965		25B. NAME OF REGISTRAR Robert E. Taylor M.D.	25C. FUNERAL DIRECTOR ADDRESS Mansfield Pkwy 638 N 6, m or st		



1

65 8101

BALTIMORE CITY HEALTH DEPARTMENT

65 8101

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

H-620

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) VELMA O. HARRIS

2. DATE AND HOUR PRONOUNCED DEAD 8/3/65 2:25 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 502 N. Calhoun St.

5. SEX female

6. RACE colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married (Sep)

8. DATE OF BIRTH July 28, 1906

9. AGE (In years last birthday) 59

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

11. BIRTHPLACE (State or foreign country) Norfolk Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Edward Segean

14. MOTHER'S MAIDEN NAME Lillian Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 216-10-2525

17. INFORMANT Lillian Wells

ADDRESS 2871 W. La Fayette Ave.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH

Massive pulmonary embolism

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

21E. INJURY OCCURRED WHILE AT WORK OR NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 8/3/65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial

23B. DATE Aug 7, 1965

23C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.

23D. LOCATION (City, town, or county) (State) Balto. Md.

24A. DATE REC'D BY HEALTH DEPT. AUG 5 1965

24B. NAME OF REGISTRAR Robert E. Farkner

24C. FUNERAL DIRECTOR Williams Funeral Home

ADDRESS 319 N. Schaefer St.

VS 151-REV. 1/1/65

THE UNIVERSITY OF CHICAGO

WALSH

Marion, John, 1875

Marion, John

Marion, John

Marion, John, 1875

Marion, John

Marion, John

No.

WALSH

Marion, John, 1875

Marion, John

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8102		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8102	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOHN George Albert DAMM		2. DATE AND HOUR OF DEATH 8-4-65 1:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL		A. STATE MARYLAND B. COUNTY BALTIMORE			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21214			
		D. STREET ADDRESS (If rural, give location) 3215 TYNDALE AVENUE			
5. SEX MALE	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-14-93	9. AGE (In years lost birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired -		10B. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FREDERICK DAMM		14. MOTHER'S MAIDEN NAME MATILDA REESE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-07-6060		17. INFORMANT WIFE- MARIE C. DAMM - S/A	
18. 334X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) BRAIN EDEMA. - CARDIAC ARREST DUE TO (B) Left BRAIN PATHOCLOGY - TYPE UNKNOWN. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 8-2-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PRESSURE INCREASED INTRACRANIAL		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (APPROX.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7/29 1965 to 8/4 1965 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/4 1965 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE Ivan L. Butler		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/4/65	
23C. PHYSICIAN'S NAME (Type) IVAN L. BUTLER		23D. ADDRESS M.D. UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/7/65	24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS INC. BALTIMORE, MARYLAND 21213	

48719208 9712320-00

MARKS DATE

15 EP-41-01

15/05/2023 - 15/05/2023

040, 450, 460, 470, 480, 490, 500, 510, 520, 530, 540, 550, 560, 570, 580, 590, 600, 610, 620, 630, 640, 650, 660, 670, 680, 690, 700, 710, 720, 730, 740, 750, 760, 770, 780, 790, 800, 810, 820, 830, 840, 850, 860, 870, 880, 890, 900, 910, 920, 930, 940, 950, 960, 970, 980, 990, 1000, 1010, 1020, 1030, 1040, 1050, 1060, 1070, 1080, 1090, 1100, 1110, 1120, 1130, 1140, 1150, 1160, 1170, 1180, 1190, 1200, 1210, 1220, 1230, 1240, 1250, 1260, 1270, 1280, 1290, 1300, 1310, 1320, 1330, 1340, 1350, 1360, 1370, 1380, 1390, 1400, 1410, 1420, 1430, 1440, 1450, 1460, 1470, 1480, 1490, 1500, 1510, 1520, 1530, 1540, 1550, 1560, 1570, 1580, 1590, 1600, 1610, 1620, 1630, 1640, 1650, 1660, 1670, 1680, 1690, 1700, 1710, 1720, 1730, 1740, 1750, 1760, 1770, 1780, 1790, 1800, 1810, 1820, 1830, 1840, 1850, 1860, 1870, 1880, 1890, 1900, 1910, 1920, 1930, 1940, 1950, 1960, 1970, 1980, 1990, 2000, 2010, 2020, 2030, 2040, 2050, 2060, 2070, 2080, 2090, 2100, 2110, 2120, 2130, 2140, 2150, 2160, 2170, 2180, 2190, 2200, 2210, 2220, 2230, 2240, 2250, 2260, 2270, 2280, 2290, 2300, 2310, 2320, 2330, 2340, 2350, 2360, 2370, 2380, 2390, 2400, 2410, 2420, 2430, 2440, 2450, 2460, 2470, 2480, 2490, 2500, 2510, 2520, 2530, 2540, 2550, 2560, 2570, 2580, 2590, 2600, 2610, 2620, 2630, 2640, 2650, 2660, 2670, 2680, 2690, 2700, 2710, 2720, 2730, 2740, 2750, 2760, 2770, 2780, 2790, 2800, 2810, 2820, 2830, 2840, 2850, 2860, 2870, 2880, 2890, 2900, 2910, 2920, 2930, 2940, 2950, 2960, 2970, 2980, 2990, 3000, 3010, 3020, 3030, 3040, 3050, 3060, 3070, 3080, 3090, 3100, 3110, 3120, 3130, 3140, 3150, 3160, 3170, 3180, 3190, 3200, 3210, 3220, 3230, 3240, 3250, 3260, 3270, 3280, 3290, 3300, 3310, 3320, 3330, 3340, 3350, 3360, 3370, 3380, 3390, 3400, 3410, 3420, 3430, 3440, 3450, 3460, 3470, 3480, 3490, 3500, 3510, 3520, 3530, 3540, 3550, 3560, 3570, 3580, 3590, 3600, 3610, 3620, 3630, 3640, 3650, 3660, 3670, 3680, 3690, 3700, 3710, 3720, 3730, 3740, 3750, 3760, 3770, 3780, 3790, 3800, 3810, 3820, 3830, 3840, 3850, 3860, 3870, 3880, 3890, 3900, 3910, 3920, 3930, 3940, 3950, 3960, 3970, 3980, 3990, 4000, 4010, 4020, 4030, 4040, 4050, 4060, 4070, 4080, 4090, 4100, 4110, 4120, 4130, 4140, 4150, 4160, 4170, 4180, 4190, 4200, 4210, 4220, 4230, 4240, 4250, 4260, 4270, 4280, 4290, 4300, 4310, 4320, 4330, 4340, 4350, 4360, 4370, 4380, 4390, 4400, 4410, 4420, 4430, 4440, 4450, 4460, 4470, 4480, 4490, 4500, 4510, 4520, 4530, 4540, 4550, 4560, 4570, 4580, 4590, 4600, 4610, 4620, 4630, 4640, 4650, 4660, 4670, 4680, 4690, 4700, 4710, 4720, 4730, 4740, 4750, 4760, 4770, 4780, 4790, 4800, 4810, 4820, 4830, 4840, 4850, 4860, 4870, 4880, 4890, 4900, 4910, 4920, 4930, 4940, 4950, 4960, 4970, 4980, 4990, 5000, 5010, 5020, 5030, 5040, 5050, 5060, 5070, 5080, 5090, 5100, 5110, 5120, 5130, 5140, 5150, 5160, 5170, 5180, 5190, 5200, 5210, 5220, 5230, 5240, 5250, 5260, 5270, 5280, 5290, 5300, 5310, 5320, 5330, 5340, 5350, 5360, 5370, 5380, 5390, 5400, 5410, 5420, 5430, 5440, 5450, 5460, 5470, 5480, 5490, 5500, 5510, 5520, 5530, 5540, 5550, 5560, 5570, 5580, 5590, 5600, 5610, 5620, 5630, 5640, 5650, 5660, 5670, 5680, 5690, 5700, 5710, 5720, 5730, 5740, 5750, 5760, 5770, 5780, 5790, 5800, 5810, 5820, 5830, 5840, 5850, 5860, 5870, 5880, 5890, 5900, 5910, 5920, 5930, 5940, 5950, 5960, 5970, 5980, 5990, 6000, 6010, 6020, 6030, 6040, 6050, 6060, 6070, 6080, 6090, 6100, 6110, 6120, 6130, 6140, 6150, 6160, 6170, 6180, 6190, 6200, 6210, 6220, 6230, 6240, 6250, 6260, 6270, 6280, 6290, 6300, 6310, 6320, 6330, 6340, 6350, 6360, 6370, 6380, 6390, 6400, 6410, 6420, 6430, 6440, 6450, 6460, 6470, 6480, 6490, 6500, 6510, 6520, 6530, 6540, 6550, 6560, 6570, 6580, 6590, 6600, 6610, 6620, 6630, 6640, 6650, 6660, 6670, 6680, 6690, 6700, 6710, 6720, 6730, 6740, 6750, 6760, 6770, 6780, 6790, 6800, 6810, 6820, 6830, 6840, 6850, 6860, 6870, 6880, 6890, 6900, 6910, 6920, 6930, 6940, 6950, 6960, 6970, 6980, 6990, 7000, 7010, 7020, 7030, 7040, 7050, 7060, 7070, 7080, 7090, 7100, 7110, 7120, 7130, 7140, 7150, 7160, 7170, 7180, 7190, 7200, 7210, 7220, 7230, 7240, 7250, 7260, 7270, 7280, 7290, 7300, 7310, 7320, 7330, 7340, 7350,

Freezer - 2 Days

17414 DA 40 419411

FUNERAL DIRECTOR: IMPORTANT

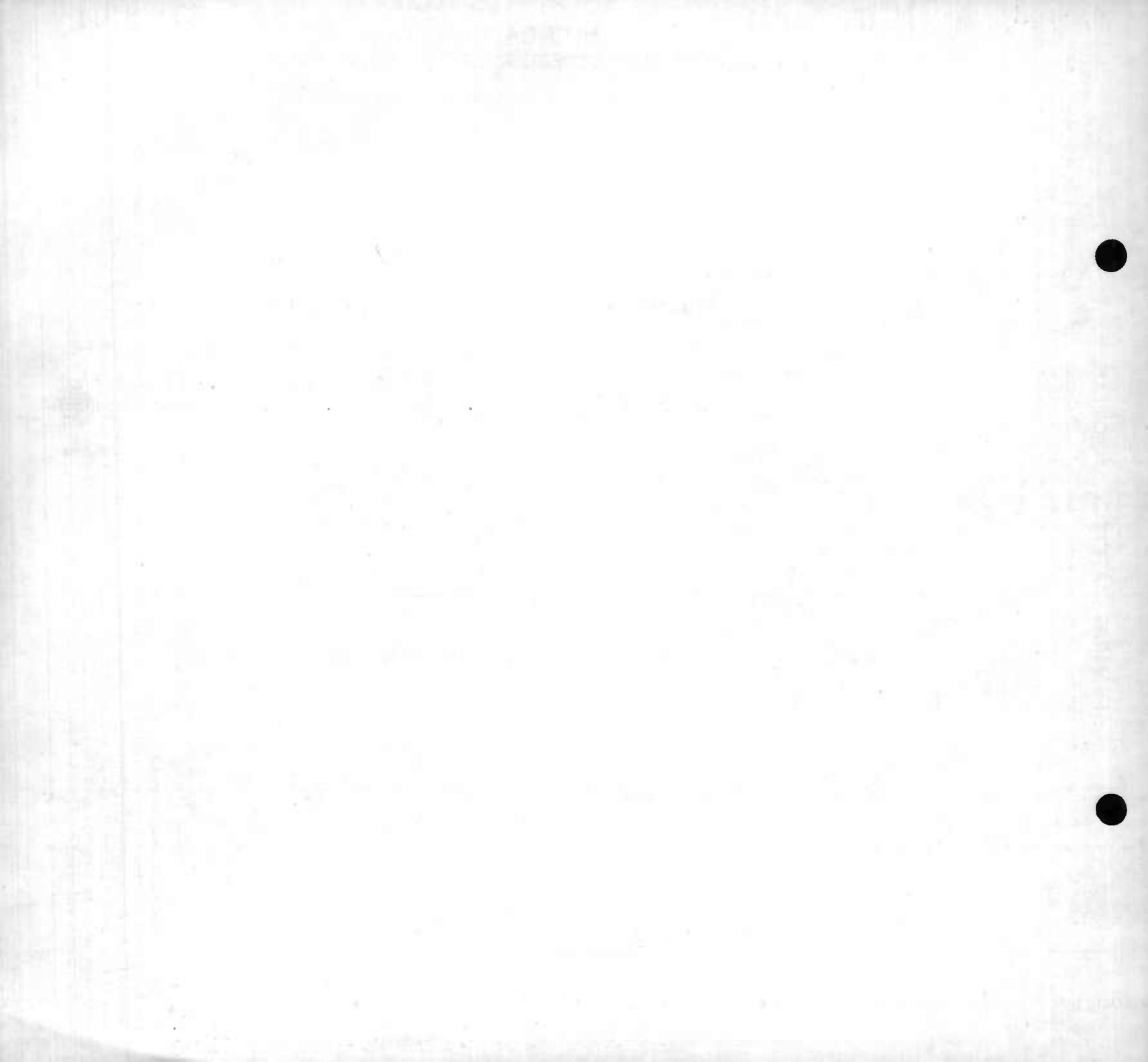
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8103		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8103	
CERTIFICATE OF DEATH M.E. CASE NO. (GEORGE ROBINSON LEWIS) 1. NAME OF DECEASED (Type or Print) <i>Lewis, George Robinson</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		2. DATE AND HOUR OF DEATH <i>8/4/65 2-10 PM</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>44 Union Memorial Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Balto</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 21234 53-00</i> D. STREET ADDRESS (If rural, give location) <i>7802 Hillway Ave</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>6-5-93</i>	9. AGE (In years lost birthday) <i>72 years</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Auto Mechanic</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland Vienna</i>	
13. FATHER'S NAME <i>Levin Lewis</i>			14. MOTHER'S MAIDEN NAME <i>Sarah Marshall</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes 1918 to 1919</i>		16. SOCIAL SECURITY NO. <i>216 05 4218</i>		17. INFORMANT <i>Mrs Marie K. Lewis</i> ADDRESS <i>7802 Hillway</i>	
18. <i>331X I</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8-1-65</i> to <i>8-4-65</i> , that (I) (we) last saw the deceased alive on <i>8-3-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>K. M. Anandiah</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>8/4/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>K. M. ANANDIAH</i>		23D. ADDRESS <i>Union Memorial Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/7/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore Maryland</i>	
24D. LOCATION (City, town, or county) <i>Baltimore Maryland</i>		24E. LOCATION (State) <i>Baltimore Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 5 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Finkbeiner</i>		25C. FUNERAL DIRECTOR <i>Henry Sander & Sons Inc.</i>	
				ADDRESS <i>Baltimore Maryland 21213</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 8104		CERTIFICATE OF DEATH		65 8104	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mrs LENA Wollschlager		2. DATE AND HOUR OF DEATH 8/4/65 7 AM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hosp.		A. STATE md. B. COUNTY 14-03			
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed.		10B. KIND OF BUSINESS OR INDUSTRY Housewife		8. DATE OF BIRTH 6/16/1899 9. AGE (In years lost birthday) 74	
13. FATHER'S NAME George Kreswell		14. MOTHER'S MAIDEN NAME Margaret Gallagher		11. BIRTHPLACE (State or foreign country) Virginia, Roanoke	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No 215 03 4731		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? USA	
17. INFORMANT Mr. William T. Wollschlager Pasadena		ADDRESS Sunset Knoll RT.# 5 Box 64			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH MD	
ANTECEDENT CAUSES		(A) Shock + Sup. inf mesenteric arterial occlusion.		5 hrs.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Diabetes Mellitus		Yrs.	
		(C) Arteriosclerosis		Yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/3 19 65 to 8/4 19 65, that (I) (we) last saw the deceased alive on 8/4 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E Lee Robbins		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/4/65	
23C. PHYSICIAN'S NAME (Type) E/ Lee Robbins		23D. ADDRESS Mercy Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/65		24C. NAME of CEMETERY or CREMATORY Saint Mary's, Hampden	
24D. LOCATION Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 5 1965			
25B. NAME OF REGISTRAR Robert E. Salama		25C. FUNERAL DIRECTOR HENRY SANDER & SONS INC. ADDRESS BALTIMORE MARYLAND 21213			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W 500 1		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8105	
BIRTH NO. 65 8105		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WANN, DORA E.		2. DATE AND HOUR OF DEATH 8/4/65 2:55 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-06		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21214	
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		D. STREET ADDRESS (If rural, give location) 2822 HEMLOCK AVENUE			
5. SEX F	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 1/19/83	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME GEORGE T. ELLIOTT		14. MOTHER'S MAIDEN NAME KATTIE M. BROOKS		17. INFORMANT 2822 Hemlock Ave. ADDRESS MELVIN WANN S/A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215 03 1085		16. SOCIAL SECURITY NO. 4444	
18. 465 X 1		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO pulmonary embolism		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 8/1/65 19 65 to 8/4 19 65 , that the (we) last saw the deceased alive on 8/4 19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. He (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert N. Whitlock		M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/4/65	
23C. PHYSICIAN'S NAME ROBERT N. WHITLOCK		23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/7/65	24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1965		25B. NAME OF REGISTRAR Robert E. Fairley		25C. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS INC. BALTIMORE MARYLAND 21213	

WARDEN
PRISON
2825 HENRY AVENUE

1/1/12 25

PRISONER NO. 34119

KATHIE M. BROWN

METWIN PRISON 2/1

UNITED STATES MARSHAL SERVICE

WIDOWED F. WHITE

HOUSEWIFE

GEORGE T. WHITE

2/1

432

8/1/12 25

2/1/12 25

UNITED STATES MARSHAL SERVICE

GEORGE T. WHITE

UNITED STATES MARSHAL SERVICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8106		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8106	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Peter Kozera</i>		2. DATE AND HOUR OF DEATH <i>August 3, 1965 5:15 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Church Home & Hospital Baltimore, Md</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>453 Barrinson Rd</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>4/28/90</i>	9. AGE (In years last birthday) <i>75</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LONG SHOREMAN</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Poland</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>?</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>715-69-3466</i>		17. INFORMANT <i>FLORENCE KOZERA 705 S. CHESTER ST.</i>	
18. <i>491X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Aspiration pneumonia</i> DUE TO <i>St. Louis like</i> <i>St. Louis & pulm. edema</i> (B) <i>Aspiration</i> DUE TO <i>Pulm. fibrosis</i> (C) <i>Pulm. fibrosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Pulm. fibrosis 5th apices</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7-28</i> 19 <i>65</i> to <i>8-3</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>8-3</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>José S. Maisog M.D.</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8-3-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>José S. Maisog M.D.</i>		23D. ADDRESS <i>Church Home & Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>8/7/65</i>		24C. NAME OF CEMETERY OR CREMATORY <i>HOly ROSARY CEMETERY</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTIMORE CO, MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 5 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Fabe...</i>		25C. FUNERAL DIRECTOR <i>JOHN H. WOOD & SONS INC 401 S. CHESTER</i>			

Handwritten text, possibly a signature or date, including the word "April" and "1864".

65 8107

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 8107

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CAROLINE CUMMINS

2. DATE AND HOUR PRONOUNCED DEAD

8/2/65 8:45 p.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospitals

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

639 S. Decker Ave.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

12/30/1883

9. AGE (In years
last birthday)

82

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Leroy Cummins 813 S. Streeper St

18. E 90401

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Subdural hematoma
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

639 S. Decker Ave.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

7 28 65 11:45p

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

fell at home

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/3/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/7/65

23C. NAME of CEMETERY or CREMATORY

Sacred Heart of Jesus

23D. LOCATION

(City, town, or county)

Baltimore Co. Md.

(Total)

24A. DATE REC'D BY HEALTH DEPT.

AUG 5 1965

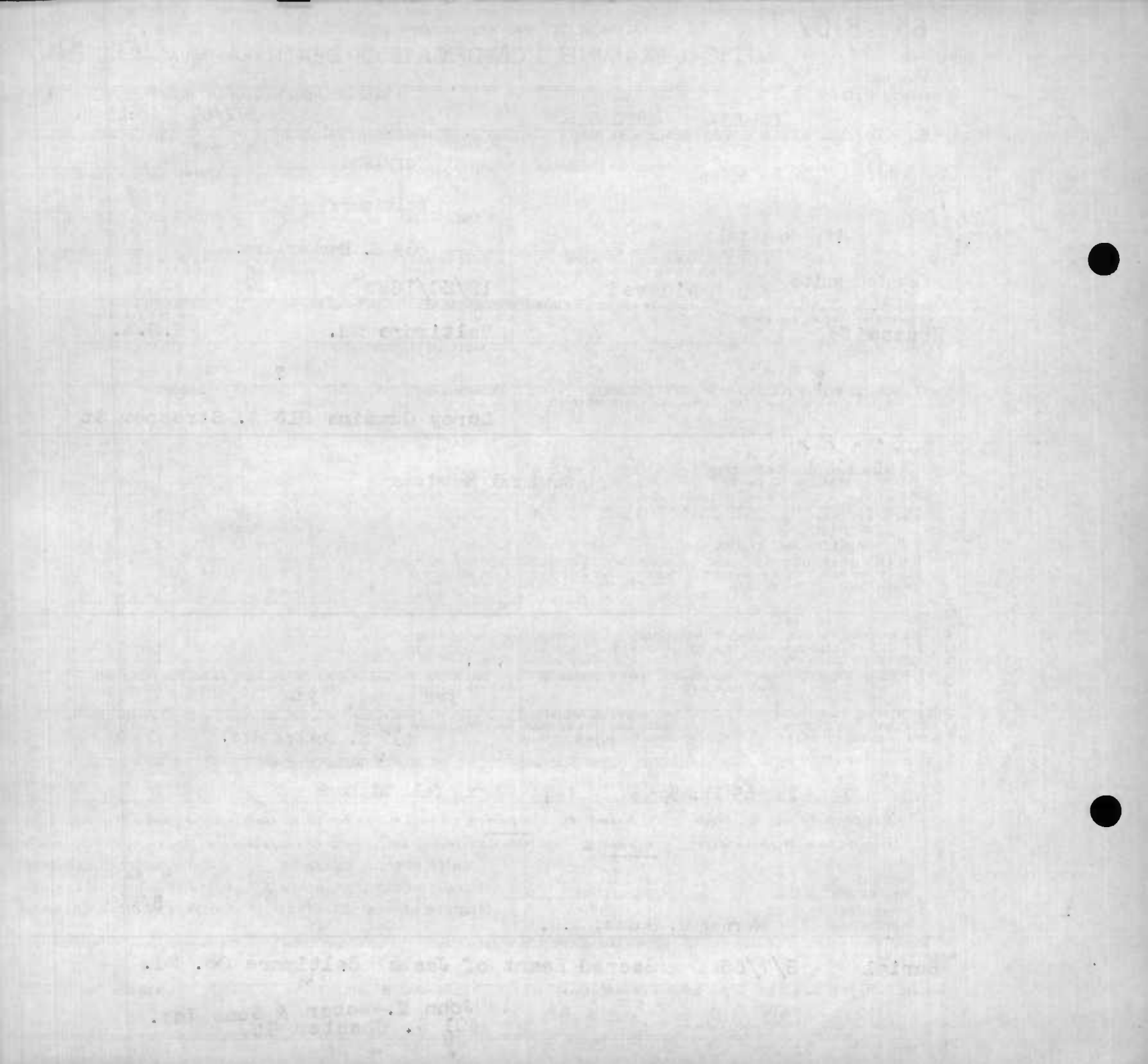
24B. NAME OF REGISTRAR

Robert E. Farkas, M.D.

24C. FUNERAL DIRECTOR

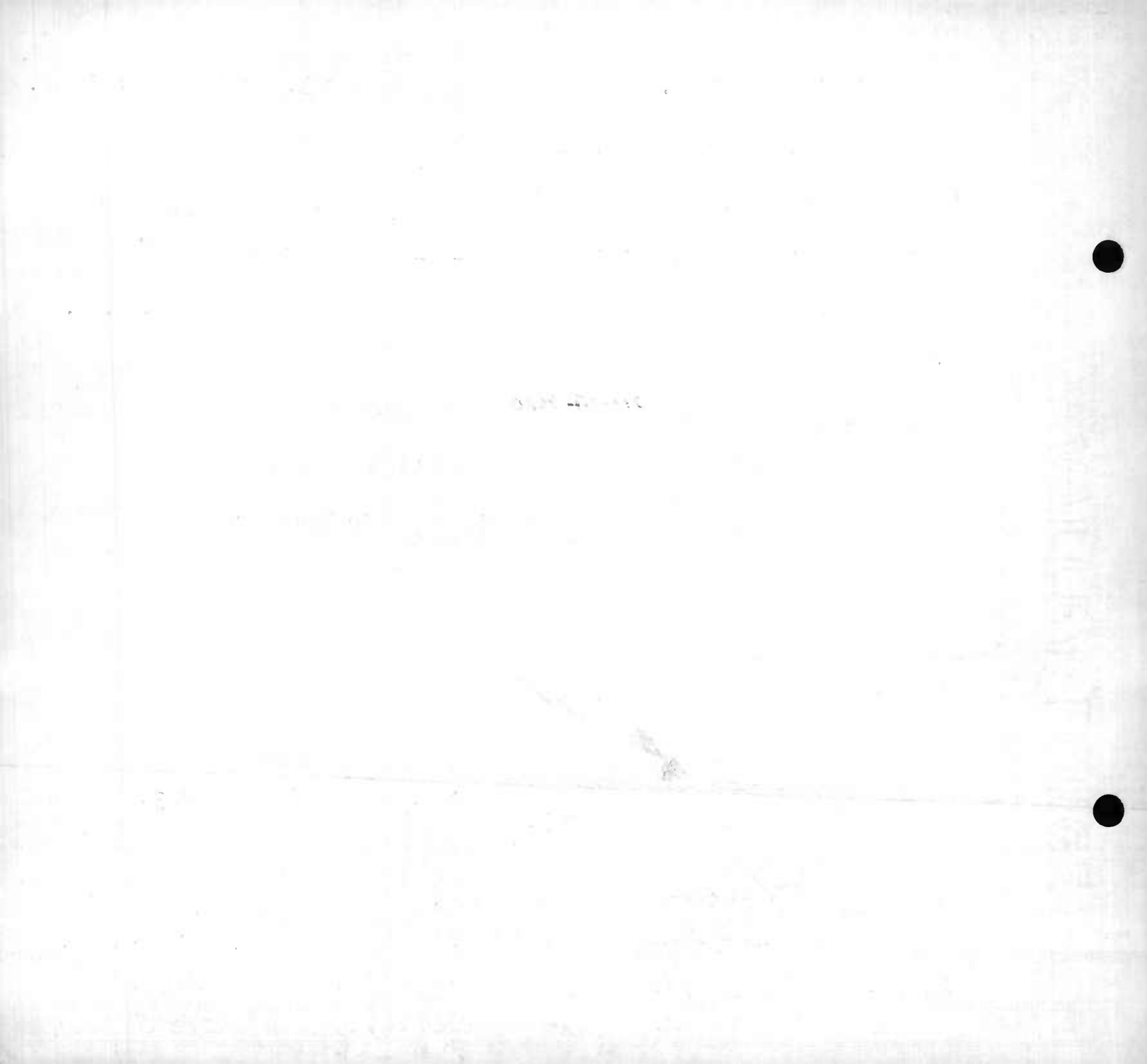
John M. Weber & Sons Inc.
401 S. Chester St

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8108	
D 625 65 8108				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) William Durkin				2. DATE AND HOUR OF DEATH August 3, 1965 7:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
				D. STREET ADDRESS (If rural, give location) 3501 E. Baltimore Street 21224	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7-28-1909	9. AGE (In years last birthday) 56	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night-Mech. Repair. Sparrows Pt.			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME John			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-07 9620		
			17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH 1 Day	
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 2, 1965 to August 3, 1965, that (I) (we) lost saw the deceased alive on August 3, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Howard Rathbun				23B. DATE SIGNED August 3, 1965	
23C. PHYSICIAN'S NAME (Type) Howard Rathbun				23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. 21224	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 8/6/65		24C. NAME OF CEMETERY or CREMATORY Moreland Mem. Park	
24D. LOCATION Baltimore, Md.		24E. NAME OF REGISTRAR Robert E. Fagundes		24F. FUNERAL DIRECTOR Joseph J. Zennaro	
24G. DATE REC'D BY HEALTH DEPT. AUG 5 1965		24H. NAME OF REGISTRAR Robert E. Fagundes		24I. ADDRESS 263 S. Conkling St.	



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S 146

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
MARLENE SHIPLEY		7/30/65 12:54 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
South Baltimore General		A. STATE Maryland B. COUNTY 1-02	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
43 South Baltimore General		Baltimore	
D. STREET ADDRESS (If rural, give location)		341 S. Ellwood Ave.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
female	white	MARRIED	MAY 14-1946
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
NONE		NONE	Baltimore Md
12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Louis Comi		IRENE Updegraff	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
+		—	IRENE Comi 341 S. Ellwood
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
Craniocerebral injury			
(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) DUE TO
			(C)
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		no	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
	street	Key Hwy. near Battery Ave.	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
7 29 65 11:00p	WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	struck by tractor-trailor	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
Werner U. Spitz		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	7/30/65
EXAMINER'S NAME (Type)		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
Werner U. Spitz, M.D.			
23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME OF CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
BURIAL	AUG 3, 1965	Gardens of Faith	Balto Md
24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
AUG 5 1965	Robert E. Taylor	Joseph N. Zannino	263 S. Conkling

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8110	
BIRTH NO. 65 8110		CERTIFICATE OF DEATH			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) William F. Kulis			2. DATE AND HOUR OF DEATH 8-4-65 8:55 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital Baltimore Md			A. STATE Maryland B. COUNTY Baltimore		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00		
			D. STREET ADDRESS (If rural, give location) 5616 East Ave. 21206		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 2/25/1899	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Sugar Refinery		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Frank Kulis			14. MOTHER'S MAIDEN NAME Eva Choranziewicz		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes (one)			16. SOCIAL SECURITY NO. 112096098		
17. INFORMANT Charles W. Kulis			ADDRESS Chant (wife) 5616 East Ave 6		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) HEMORRHAGIC PERICARDIAL EFFUSION			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO METASTATIC CARCINOMA TO PERICARDIUM (B) DUE TO CARCINOMA OF LUNG, RESECTED (4 yrs) (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/2/65 1965 to Aug 4 1965, that (I) (we) last saw the deceased alive on Aug 4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael Gould				23B. DATE SIGNED 8-4-65	
23C. PHYSICIAN'S NAME (Type) W. Michael Gould				23D. ADDRESS Md Gene Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug 7-65		24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cem.	
24D. LOCATION (City, town, or county) (State) Gormanhill Rd Balto Co Md					
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1965		25B. NAME OF REGISTRAR Robert E. Jankowski		25C. FUNERAL DIRECTOR Chippel Bros Inc 7110 Belair Rd	

England General Hospital

State of Texas
Date of Birth

M
W
Married
Frank Kull

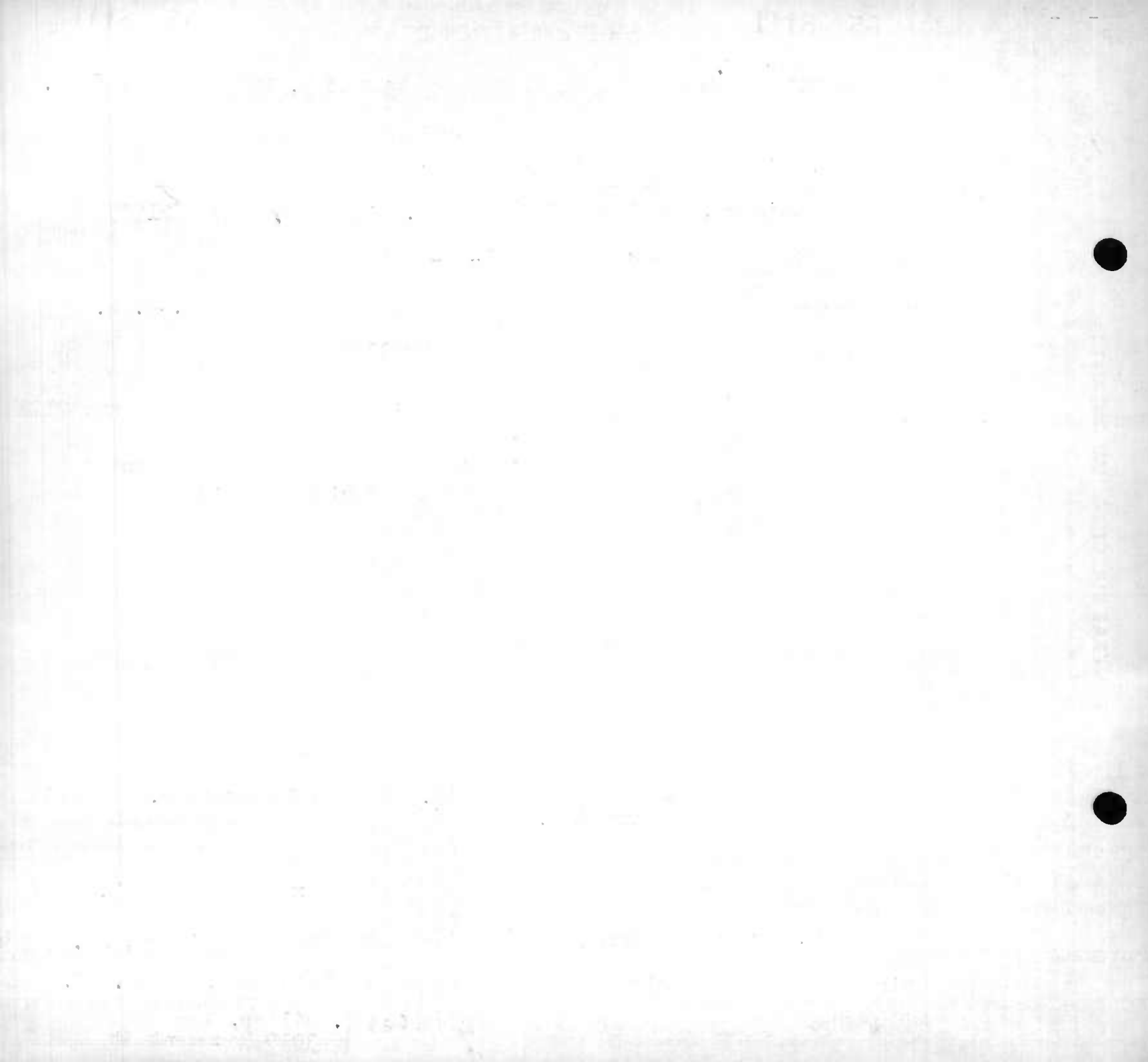
21st/1901
Married
Eva Charlotte

Aug
W. M. Kull

8/2/1901
X
X

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8111				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8111	
M.E. CASE NO. 3-650				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Henry F. Harry Schramm				2. DATE AND HOUR OF DEATH August 3, 1965 9:45 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital at institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE Maryland B. COUNTY Baltimore			
5. SEX Male				6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH 1-23-1903				9. AGE (In years last birthday) 62		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paperhanger				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Schramm				14. MOTHER'S MAIDEN NAME Moeller			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No No				16. SOCIAL SECURITY NO. 214-61-7355		17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 331X I Brain stem Cerebral Vascular Accident Cerebral Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 2 Months			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO (C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 15, 19 65 to August 3, 19 65, that (I) (we) last saw the deceased alive on August 3, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature] M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED August 3, 1965			
23C. PHYSICIAN'S NAME (Type) Dr. Howard Rathbun M.D.				23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/6/65		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Belair Road, Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1965		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Frederick D. Miller, Inc		ADDRESS 3019 Monument St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

44-31-58 ID		Baltimore City Health Department		Registered No. 65 8112	
D-40865 8112		CERTIFICATE OF DEATH			
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				Thomas Deal Charles White (Charles Thomas Skinner)	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		2. DATE AND HOUR OF DEATH		7-31-65 10:30 A M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		Maryland 17-82	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
D. STREET ADDRESS (If rural, give location)		516 W. Hoffman Street- #21201			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Male	Negro	Single	8-19-1899	65	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Unemployed				Maryland	
12. CITIZEN OF WHAT COUNTRY?		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
Thomas Deal		Laura Skinner		yes	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
		RECORDS-BCH-4940 Eastern Avenue-21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Obstructive Jaundice (B) Dehydration - Anemia (C) Hypokalemia (D) Carcinoma of Pancreas		3 months 3 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-30 19 65 to 7-31 19 65		that (I) (we) lost saw the deceased alive on 7-31 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Dr. Alex Silverman		23B. DATE SIGNED		7-31-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		#21224	
BCH-4940 Eastern Avenue-Baltimore, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	8-5-65	MT Auburn		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
AUG 5 1965	Robert E. Taylor	Morton & Dyett		1701 Laurens St	

Wm. L. Williams

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

700 Fleet Street

5. SEX

female

6. RACE

?

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

6-28-65

9. AGE (In years
last birthday)

1 day

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Suffocation

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CAUSING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

?

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

found on Winterbourne Rd.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
? ? 65 ?

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

subject was placed in plastic bag

22. Found 6/29/65 11:00 AM.
I certify that I held on InquiryInspection ☐Autopsy ☒

and that on this basis, death in my opinion

resulted from: Natural causes ☐Accident ☐Suicide ☐Homicide ☒Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/21/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

8-3-65

23C. NAME of CEMETERY or CREMATORY

MORRIS

23D. LOCATION

(City, town, or county)

(State)

700 Fleet St

24A. DATE REC'D BY HEALTH DEPT.

AUG 5 1965

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

ADDRESS

8/9/65 - Race - White - Information
received from Fed. Exam. Office
by phone - ~~gs~~

3 VALLEY FORCE

AND CONTENT

1965

2-2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

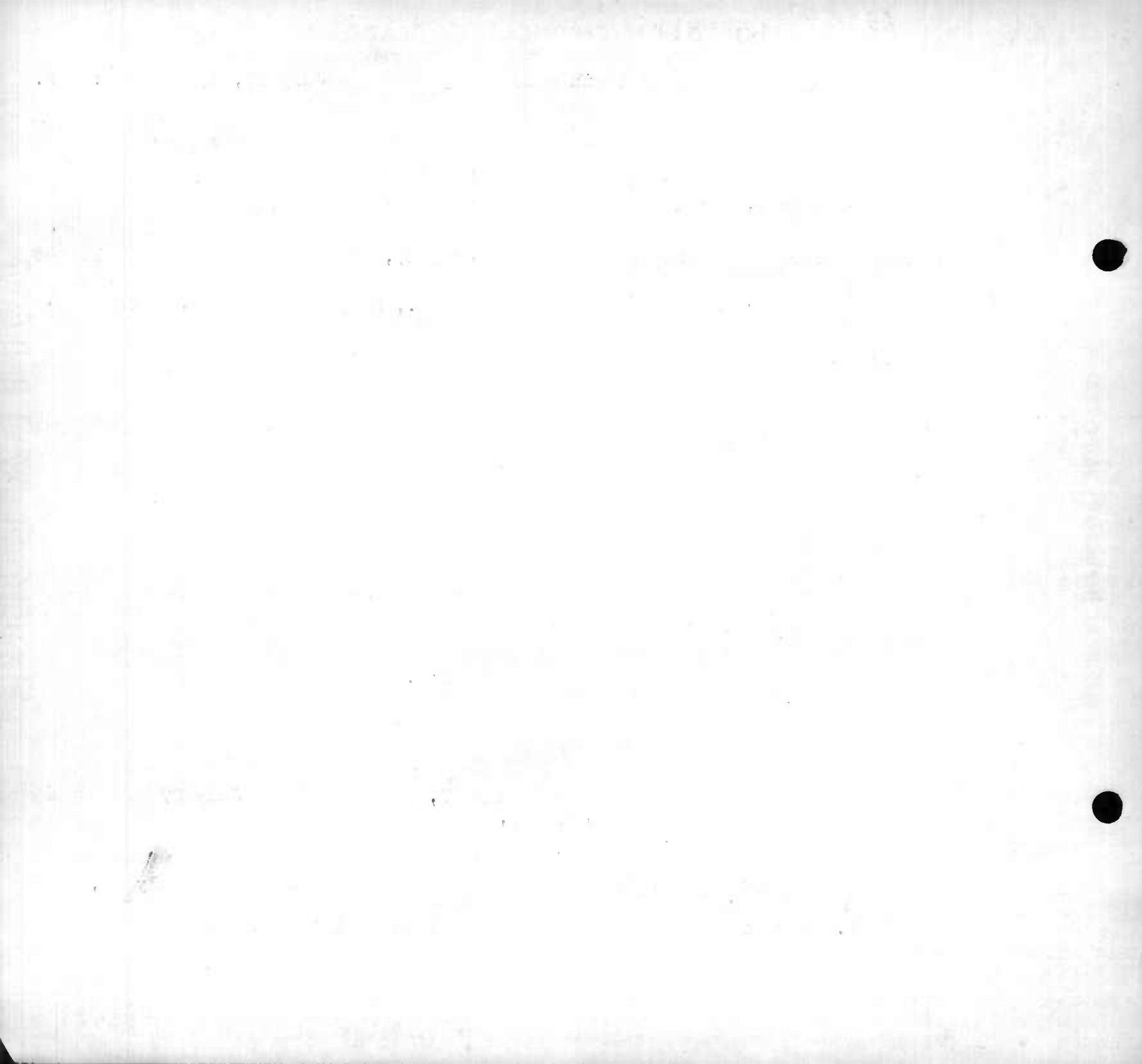
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8114	
BIRTH NO. 65 8114		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Charles Garey		2. DATE AND HOUR OF DEATH 7-30-65 4:40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 23-01			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital at institution, give street address or location) South Baltimore General Hosp.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21230			
		D. STREET ADDRESS (If rural, give location) 151 W. Henrietta St.			
5. SEX M.	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday) 74	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. I X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) CARCINOMA OF STOMACH DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (we) (this hospital) attended the deceased from 7-28 19 65 to 7-30 19 65, that (we) lost saw the deceased alive on 7-30 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. J. Hargrave M.D.				23B. DATE SIGNED 8-2-65	
23C. PHYSICIAN'S NAME (Type) HUGH J. HARGRAVE		23D. ADDRESS ANATOMY BOARD OF MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE AUG 3 1965		24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1965		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	

?

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. <u>65-18548</u> <u>65</u> <u>8115</u>		CITY HEALTH DEPARTMENT		Registered No. <u>65</u> <u>8115</u> <u>4</u>	
1. NAME OF DECEASED (Type or Print) <u>Baby of Anne Giles (twin # 2)</u>						2. DATE AND HOUR OF DEATH <u>July 27, 1965</u> <u>6:00 P. M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland</u>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>12-04</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>2121 Guilford Avenue</u>			
5. SEX <u>Female</u>		6. RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>		8. DATE OF BIRTH <u>July 27, 1965</u>		9. AGE (In years last birthday) <u>14</u> <u>48</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Giles</u>						14. MOTHER'S MAIDEN NAME <u>Anne Tracey</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>ADDRESS</u>			
18. <u>260.5</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) <u>Atelectasis neonatorum</u> DUE TO (B) <u>Cerebral hemorrhage</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes.</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>July 27, 1965</u> to <u>July 27, 1965</u> , that (I) (we) last saw the deceased alive on <u>July 27, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Manabehn M. Behrooz</u>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>July 29, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>M. Behrooz</u>		23D. ADDRESS <u>1514 Division Street</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>AUG 3 1965</u>		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <u>UNIVERSITY MEDICAL SCHOOL</u>		24D. LOCATION <u>MORTUARY SERVICE - BCHD</u>		24E. CITY, TOWN, OR COUNTY (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 5 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR		ADDRESS			



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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BIRTH NO. 65-17011		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8116	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Baby Girl Vincent - Sylvia			2. DATE AND HOUR OF DEATH July 30, 1965 1:20 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland, 21224			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1644 Barnes Street		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 7-18-65	9. AGE (In years last birthday) 13	If Under 1 Yr. Months: Days: Hours: Min. 12
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Sylvia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH, 4940 Eastern Ave., 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Septicemia			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Infected Hematoma		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Prematurity			(C)		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 18, 1965 to July 30, 1965, that (I) (we) last saw the deceased alive on July 30, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Wayne Klein				23B. DATE SIGNED JULY 30, 1965	
23C. PHYSICIAN'S NAME (Type) S. WAYNE KLEIN				23D. ADDRESS M.D. 4940 Eastern Avenue, Balto., Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 8-3-65		24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals	
24D. LOCATION Baltimore, Maryland 21224		24E. DATE REC'D BY HEALTH DEPT. AUG 5 1965			
25B. NAME OF REGISTRAR Robert S. Taylor		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL			

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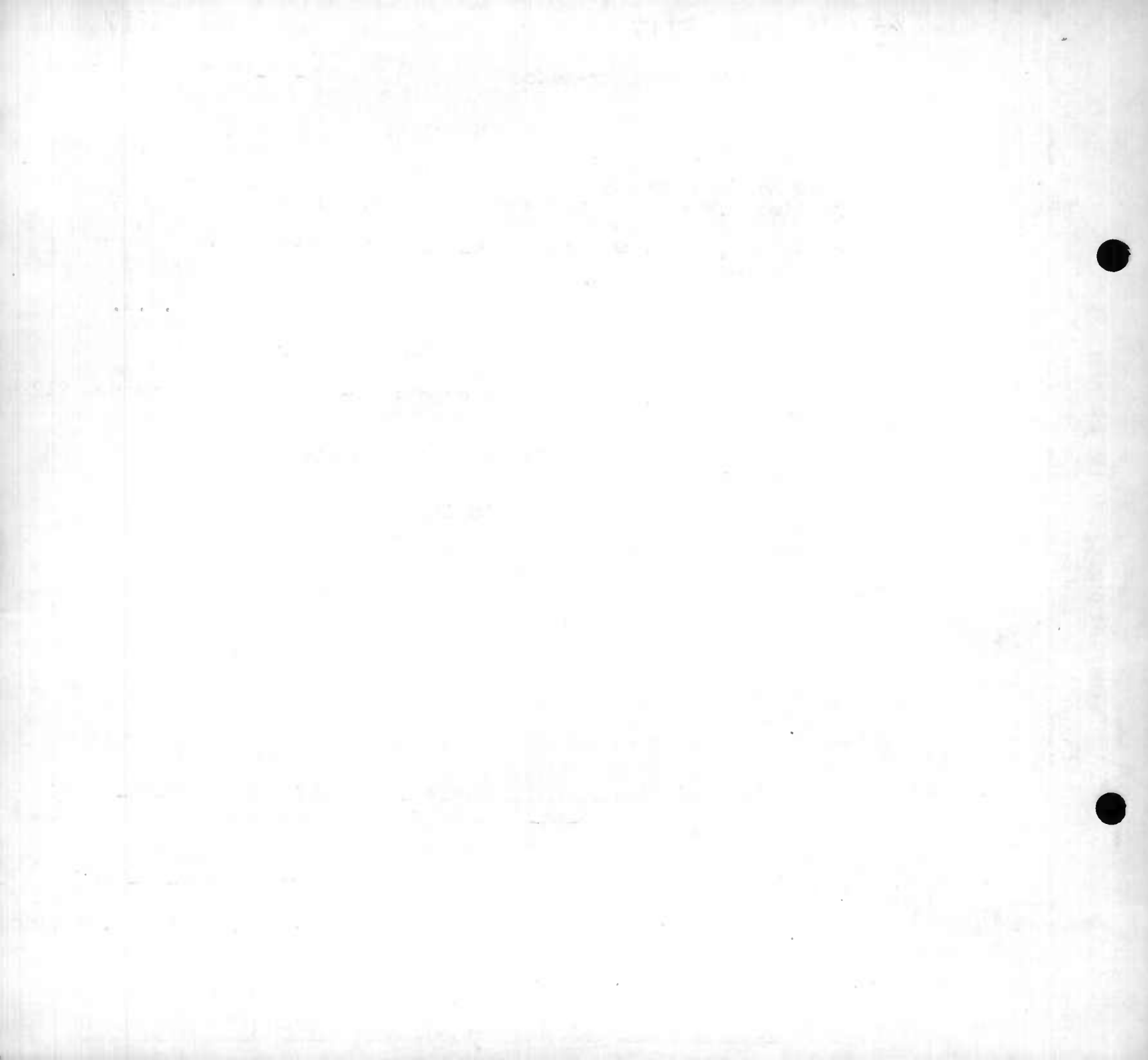
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

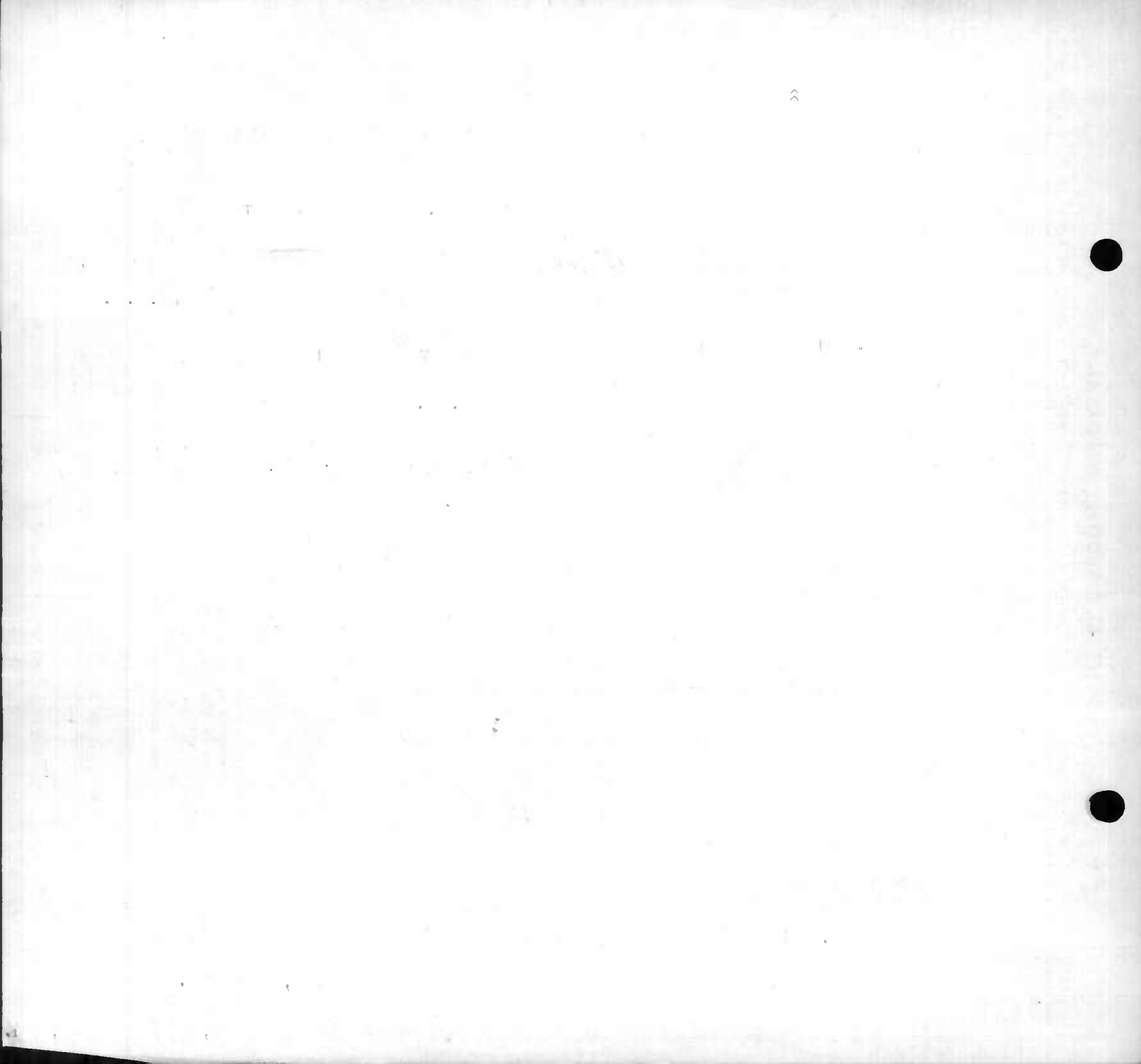
BIRTH NO. 65-18338		65 8117		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65-8117	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)			
Baby Girl Camphor-Renee				2. DATE AND HOUR OF DEATH 7-30-1965 2:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				Maryland			
5. SEX Female				6. RACE Negro			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married				8. DATE OF BIRTH 7-30-1965			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT				ADDRESS			
Records: BCH-4940 Eastern Avenue				21224			
18. 762.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) Intrauterine Anoxia DUE TO			
ANTECEDENT CAUSES				(B) Immaturity DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				Yes		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-30-1965 to 7-30-1965, that (I) (we) last saw the deceased alive on 7-30-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE S. Wayne Klein M.D.				23B. DATE SIGNED 7-30-1965			
23C. PHYSICIAN'S NAME (Type) Dr. S. Wayne Klein M.D.				23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Cremation		8-3-65		Baltimore City Hospitals		Baltimore, Maryland 21224	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 5 1965		Renee Camphor		762.5 I		HOSPITAL DISPOSAL	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

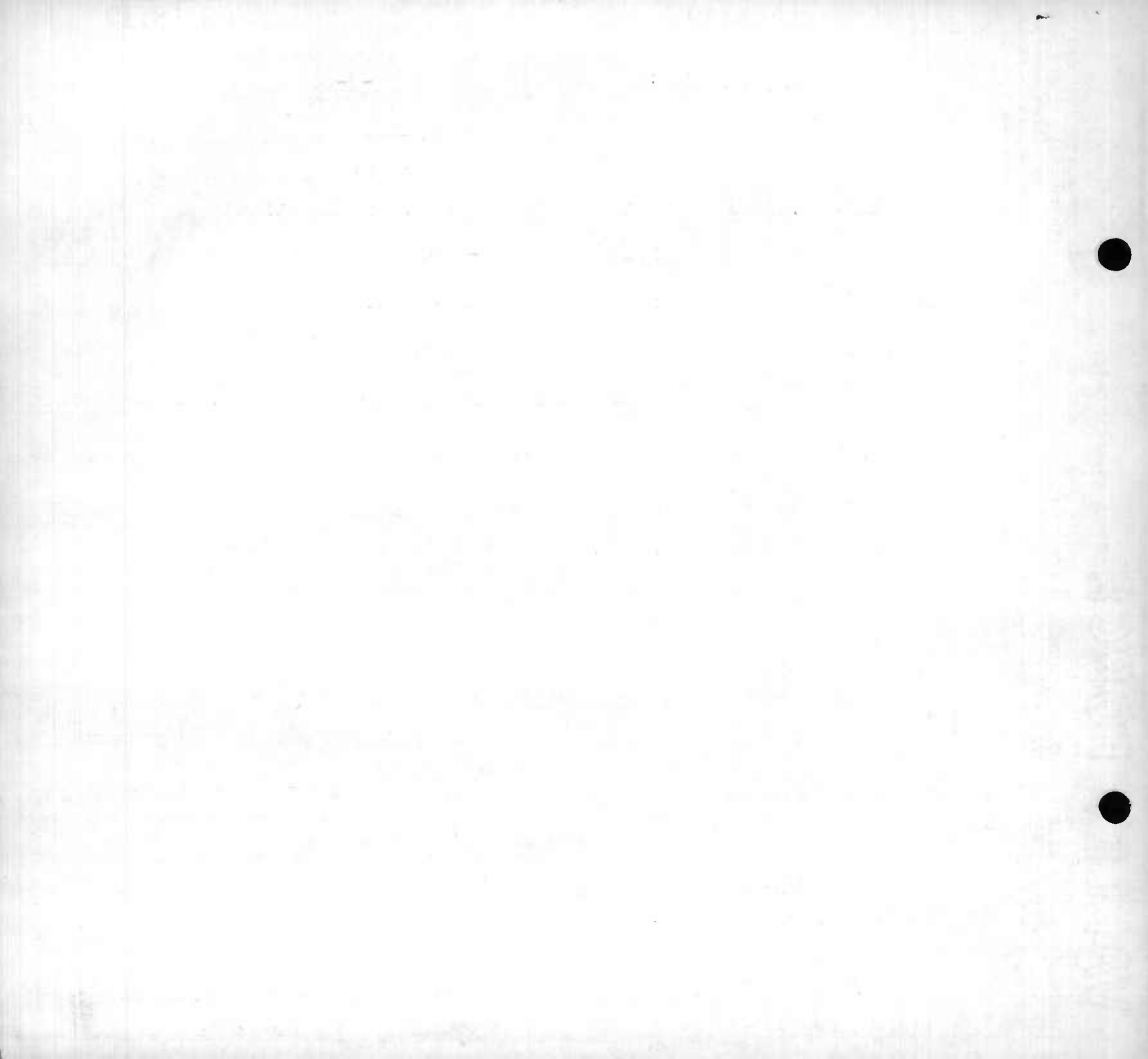
BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. <i>Harford B. No. 65 8118</i>					REGISTERED NO. <i>65 8118</i>														
1. NAME OF DECEASED (Type or Print) <i>Thompson Richard A Price</i>					2. DATE AND HOUR OF DEATH <i>8-3-65 4:15 P.M.</i>														
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>33 The Johns Hopkins Hospital</i>					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Harford</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>ABERDEEN 62-00</i> D. STREET ADDRESS (If rural, give location) <i>8 S. ROGERS STREET</i>														
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Never Married</i>		8. DATE OF BIRTH <i>28 May 65</i>	9. AGE (In years last birthday) <i>26</i>	If Under 1 Yr. Months Days Hours Min. <i>2 6</i>		If Under 24 Hrs. Min.											
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>													
13. FATHER'S NAME <i>G. RICHARD PRICE</i>					14. MOTHER'S MAIDEN NAME <i>N. Nancy Mary Ann Twitchell</i>														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mr. G. Richard Price</i>		ADDRESS <i>Same as # 4</i>													
18. <i>754.7 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					<div style="display: flex; justify-content: space-between;"> <div style="writing-mode: vertical-rl; transform: rotate(180deg);">CERTIFICATION APPROVED BY</div> <div> CAUSE OF DEATH <i>Transpiration of Great Vessels</i> <i>754.7 since birth</i> </div> </div>														
										19A. DATE OF OPERATION <i>8/3/65</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Transpiration of Great Vessels</i>				
										20A. AUTOPSY? (Yes or No) <i>YES</i>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>NO</i>				
										21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (notify medical examiner) <i>NO</i>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <i>NO</i>														
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?														
22. I certify that (I) (this hospital) attended the deceased from <i>8/3 4:15</i> to <i>8/3 65</i> that (I) (we) last saw the deceased alive on <i>8/3 4:15</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE <i>Paul H. Vincher</i>					23B. DATE SIGNED <i>3 Aug. '65</i>														
23C. PHYSICIAN'S NAME (Type) <i>PAUL H. VINCHER</i>					23D. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i>														
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-6-65</i>		24C. NAME of CEMETERY or CREMATORY <i>Glen Wood Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Smyrna, Kent Co. Delaware</i>													
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 5 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farkner</i>		25C. FUNERAL DIRECTOR <i>Ernest B. Fleming</i>		ADDRESS <i>Singleton Funeral Home, Glen Burnie, Md.</i>													



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8119		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8119	
M.E. CASE NO.			1. NAME OF DECEASED		
(Type or Print)			Stanley J. Ziemba		
2. DATE AND HOUR OF DEATH			8-2-65 9 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE Maryland B. COUNTY 26-34		
5023 E. Biddle Street			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
D. STREET ADDRESS (If rural, give location)			5023 E. Biddle Street		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 5-20-1920	9. AGE (In years lost birthday) 45	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) helper		10B. KIND OF BUSINESS OR INDUSTRY Eastern Freight		11. BIRTHPLACE (State or foreign country) Weirton W. Va	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Paul Ziemba		14. MOTHER'S MAIDEN NAME Helen Drozek	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) WWII		16. SOCIAL SECURITY NO. 216101521		17. INFORMANT Lavern Ziemba 5023 E. Biddle Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO metastatic adenocarcinoma 2 months		
			(B) DUE TO adenocarcinoma lung 6 months		
			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/16 1965 to 8/12 1965, that (I) (we) last saw the deceased alive on 7/27 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A.L. Kolodny M.D.				23B. DATE SIGNED 8/3/65	
23C. PHYSICIAN'S NAME (Type) A.L. Kolodny M.D.				23D. ADDRESS 1825 Eastern Blvd Balt. 21214	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-6-65		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 5 1965			
25B. NAME OF REGISTRAR Walter J. Babinski		25C. FUNERAL DIRECTOR			



BIRTH NO. 65 8120 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		PATRICIA TAYLOR		2. DATE AND HOUR PRONOUNCED DEAD July 31, 1965 9:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Worcester C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Girdletree D. STREET ADDRESS (If rural, give location) Rural Area	
5. SEX Female	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH Sept. 2, 1962	9. AGE (In years last birthday) 2	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md. Nassawadox, Worcester County	
13. FATHER'S NAME James Taylor			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT James Taylor ADDRESS Girdletree, Maryland	

18. CAUSE OF DEATH E936.71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) Cerebral Edema DUE TO (B) Bilateral Chronic Subdural Hematomas DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH Months to Years.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unknown		21C. WHERE DID INJURY OCCUR? Unknown		21D. TIME OF INJURY (APPROX.) Unknown	
21D. TIME OF INJURY (APPROX.) Unknown		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Unknown		21G. HOW DID INJURY OCCUR? 00-00	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/1/65	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 8/4/65		23C. NAME of CEMETERY or CREMATORY Greenbackville Cemetery		23D. LOCATION (City, town, or county) (State) Greenbackville Maryland	
24A. DATE REC'D BY HEALTH DEPT. AUG 5 1965		24B. NAME OF REGISTRAR Robert E. Farber, M.D.		24C. FUNERAL DIRECTOR George J. Gonce		24D. ADDRESS 4001 Ritchie Hwy. Baltimore, Maryland	

WALLING FORT

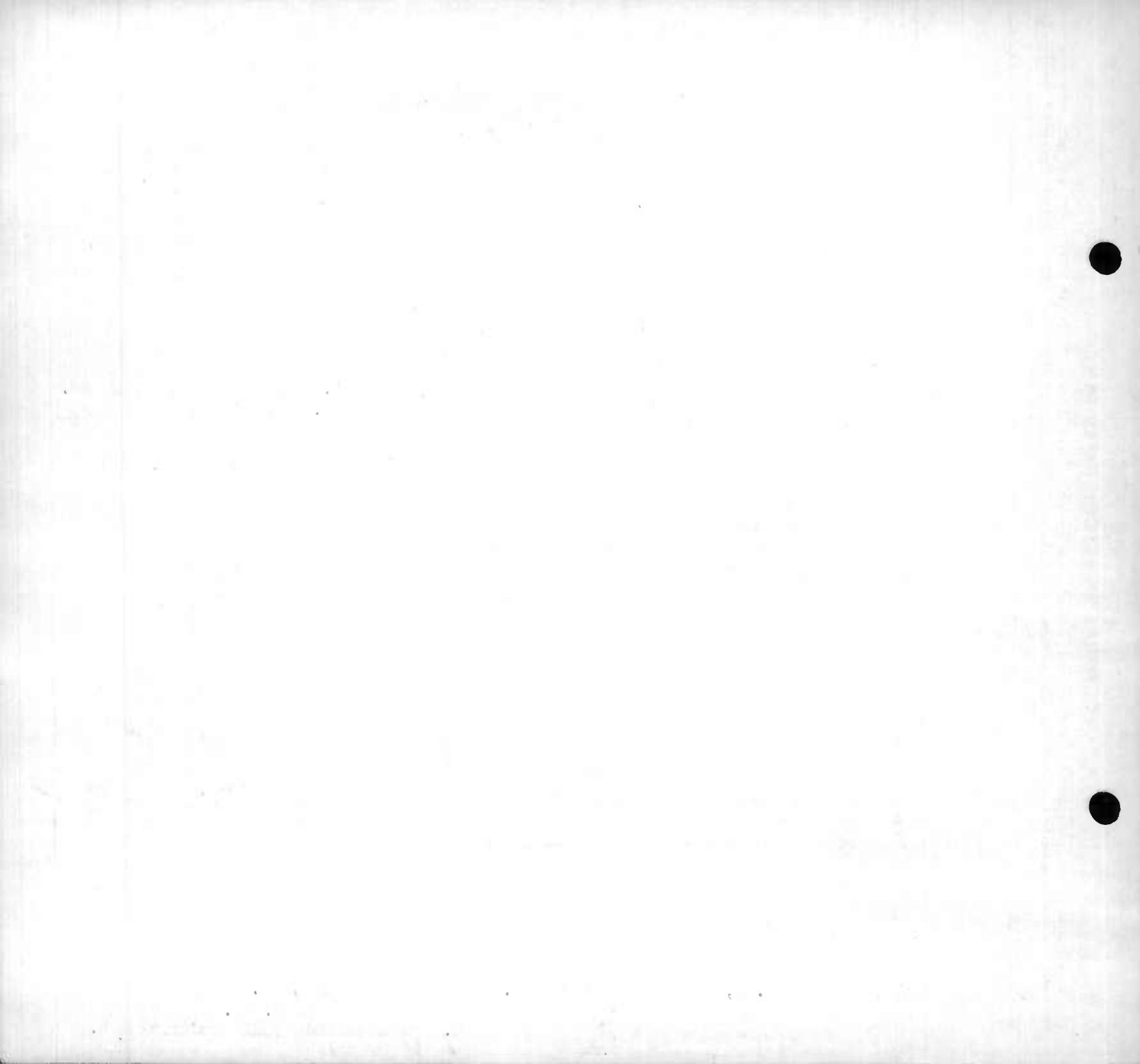
FAIRFAX COUNTY

1941

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

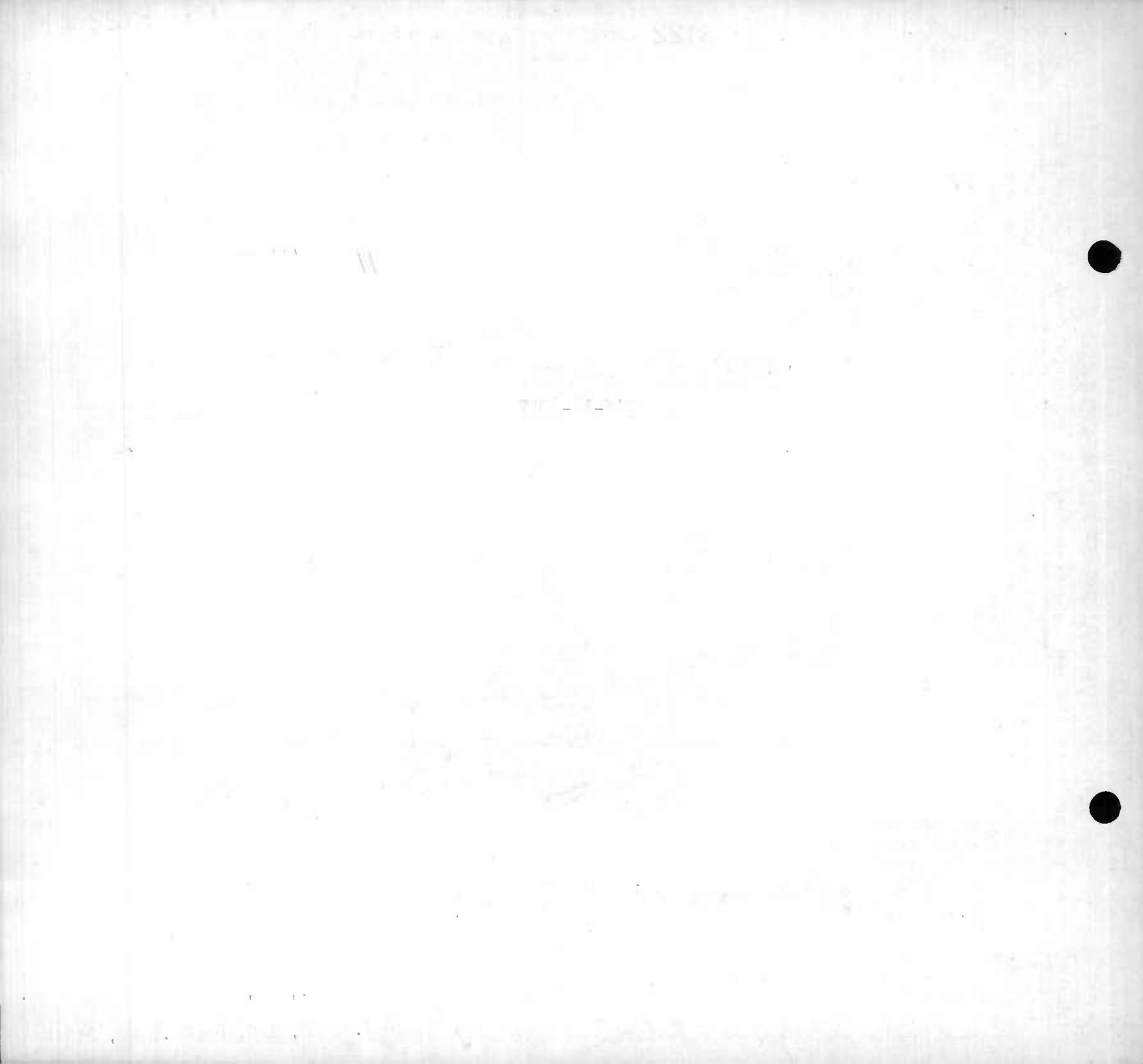
BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 55 8121					CERTIFICATE OF DEATH					Registered No. 55 8121				
1. NAME OF DECEASED (Type or Print) EUGENE RANDOLPH GIBSON					2. DATE AND HOUR OF DEATH 8/2/65 14:34 P.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL					A. STATE MARYLAND					B. COUNTY 99				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) SEVERNA PARK 62-00									
					D. STREET ADDRESS (If rural, give location) Rt 2 BOX 242									
5. SEX M		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 6/16/13		9. AGE (In years last birthday) 52		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE					10B. KIND OF BUSINESS OR INDUSTRY —					11. BIRTHPLACE (State or foreign country) WEST VIRGINIA				
12. CITIZEN OF WHAT COUNTRY? USA					13. FATHER'S NAME DOLD GIBSON					14. MOTHER'S MAIDEN NAME MARGARET COLLINS				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN					16. SOCIAL SECURITY NO. —					17. INFORMANT SAME				
					ADDRESS Rt. 2 Box 242 Severna Park Md.									
					Mrs. Ruby Gibson									
18. CAUSE OF DEATH										INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) AMYOTROPHIC LATERAL SCLEROSIS										3/29/65 → 8/2/65				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. massive Bronchopneumonia, bilateral														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —										path				
19A. DATE OF OPERATION —					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —					20A. AUTOPSY? (Yes or No) YES				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES														
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) —					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) this hospital					21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR? —				
22. I certify that (I) Walter Thomas Boone attended the deceased from JULY 24 1965 to AUG. 2 1965 , that (we) last saw the deceased alive on AUG. 2 1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.														
23A. SIGNATURE Walter Thomas Boone					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED Aug. 2, 1965				
23C. PHYSICIAN'S NAME (Type) Walter T. Boone					M.D. Union Memorial Hosp.					23D. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE Aug. 5, 1965					24C. NAME of CEMETERY or CREMATORY Loudon Park Cem.				
24D. LOCATION (City, town, or county) (State) Balto, Md.					25A. DATE REC'D BY HEALTH DEPT. AUG 5 1965					25B. NAME OF REGISTRAR Robert E. Jackson				
25C. FUNERAL DIRECTOR G. Truman Schwab					ADDRESS Balto, Md. 3512 Frederick Ave.									



FUNERAL DIRECTOR: IMPORTANT

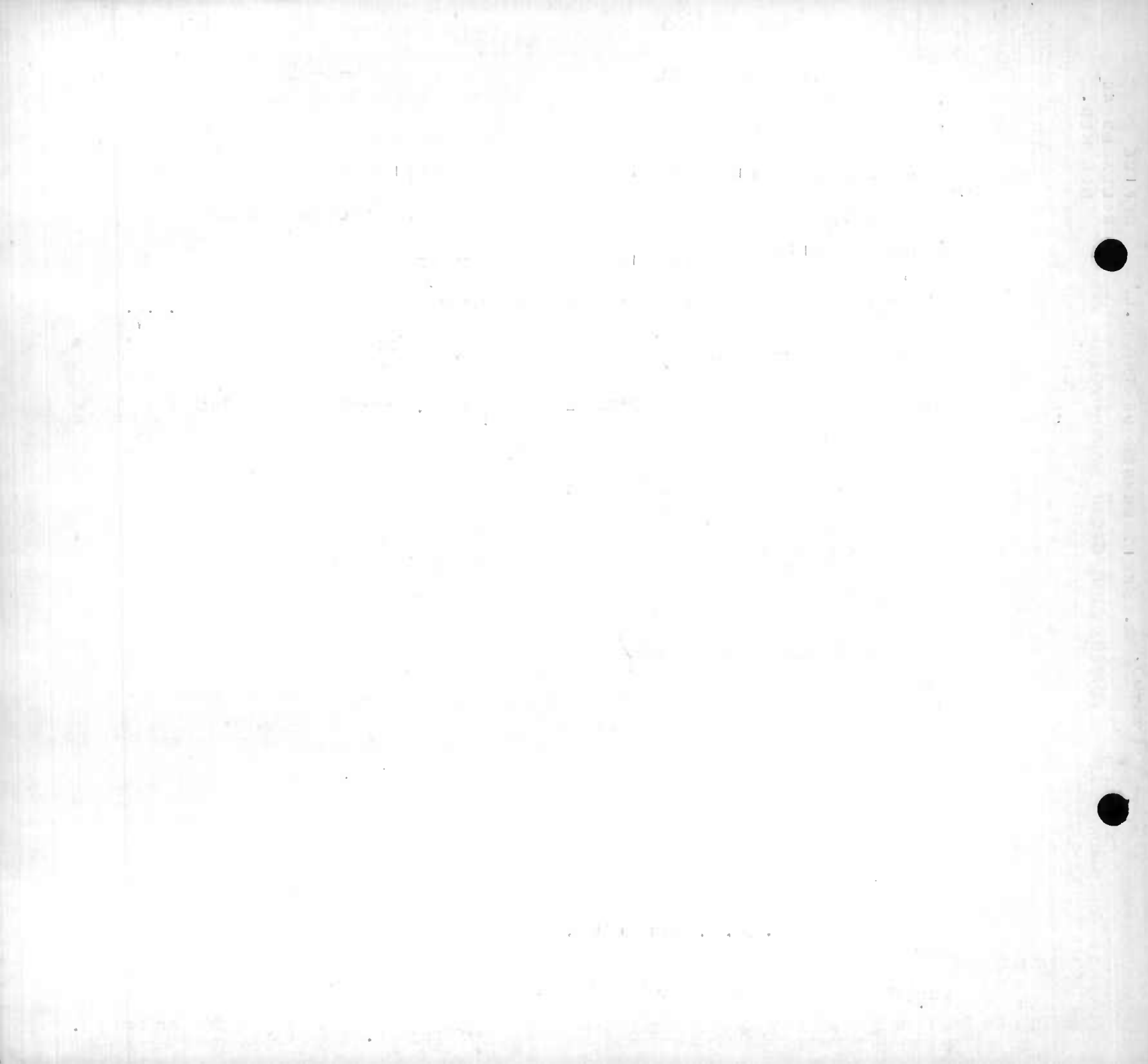
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		65 8122		BALTIMORE CITY HEALTH DEPARTMENT		65 8122	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Sybilla Miller				8/5/65 3:45 a.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Maryland Gen. Hosp. Linden Ave				Maryland 27-01			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Balto.			
				D. STREET ADDRESS (If rural, give location)			
				3909 Woodlea Ave			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours
F	W	widowed	1882 10-10-82	82			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
none			none		New Jersey		U.S.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
Hunkle, Adolph			Catherine Forma				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS
			215-78-8357		hospital chart		same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslenio, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(A) Pneumonia, aspiration DUE TO		2 wks	
				(B) CVA DUE TO		10 yrs	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0 none		-		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
X		While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		X			
22. I certify that (I) (this hospital) attended the deceased from July 27 1965 to Aug 5 1965, that (I) (we) last saw the deceased alive on Aug 4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS		Aug 5, 1965	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		8/7/65		NEW CATHEDRAL CEMETRY		BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 5 1965		Robert E. Fader		LEONARD J. RUCH, INC.		BALTO., MD. 21214	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8123		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8123	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		JOSEPH REDEL		2. DATE AND HOUR OF DEATH 8-3-65 7:05 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		THE JOHNS HOPKINS HOSPITAL		MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5818 MARLUTH AVENUE	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-11-18	9. AGE (In years last birthday) 47	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Fitter		10B. KIND OF BUSINESS OR INDUSTRY Gas & Elec Co		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN REDEL		14. MOTHER'S MAIDEN NAME FRANCES EMGE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 11		16. SOCIAL SECURITY NO. 217-14-0777		17. INFORMANT Redel Mary B. Schick 5818 Marluth Ave	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH 2 hours.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 5:20 PM 8/3 19 65 to 7:05 PM 8/3 19 65, that (1) (we) last saw the deceased alive on 8/3 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Patrick Caulfield		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/4/65	
23C. PHYSICIAN'S NAME (Type) DR. J.P. CAULFIELD.		23D. ADDRESS J.H.H.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/65		24C. NAME OF CEMETERY or CREMATORY Parkwood	
24D. LOCATION Baltimore		24E. (City, town, or county)		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Jeonard J. Ruck Inc	
25D. ADDRESS 5305 Harford Rd.					



BALTIMORE CITY HEALTH DEPARTMENT

65 8124

BIRTH NO. 65 8124 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

W-536

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) S
RAYMOND WONDERLEY - WONDERLY

2. DATE AND HOUR PRONOUNCED DEAD August 3, 1965 3:05 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 8-12-65
CERTIFICATE CORRECTED

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2909 Bayonne Avenue

5. SEX male 6. RACE white 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married

8. DATE OF BIRTH Feb. 13, 1899 9. AGE (In years last birthday) 65 66

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Refrigeration Mechanic

11. BIRTHPLACE (State or foreign country) Baltimore 12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Arthur J Wonderly 14. MOTHER'S MAIDEN NAME Ida Zepp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 215-03-7379 17. INFORMANT ADDRESS Florence Merson 2908 Bayonne Ave

18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
MASSIVE SUBARACHNOID HEMORRHAGE
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
RUPTURED CEREBRAL ANEURYSM
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 2. 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK [] NOT WHILE AT WORK [] 21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry [] Inspection [] Autopsy [x] and that on this basis, death in my opinion resulted from: Natural causes [x] Accident [] Suicide [] Homicide [] Undetermined manner []

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenacker M.D. CHIEF MEDICAL EXAMINER [] ASSISTANT MEDICAL EXAMINER [x] ASSOCIATE MEDICAL EXAMINER [] DATE SIGNED 8-4-65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 8/6/65 23C. NAME of CEMETERY or CREMATORY Baltimore 23D. LOCATION (City, town, or county) (State) Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT. AUG 5 1965 24B. NAME OF REGISTRAR Robert E. Taylor, M.D. 24C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. 5305 Harford Rd.

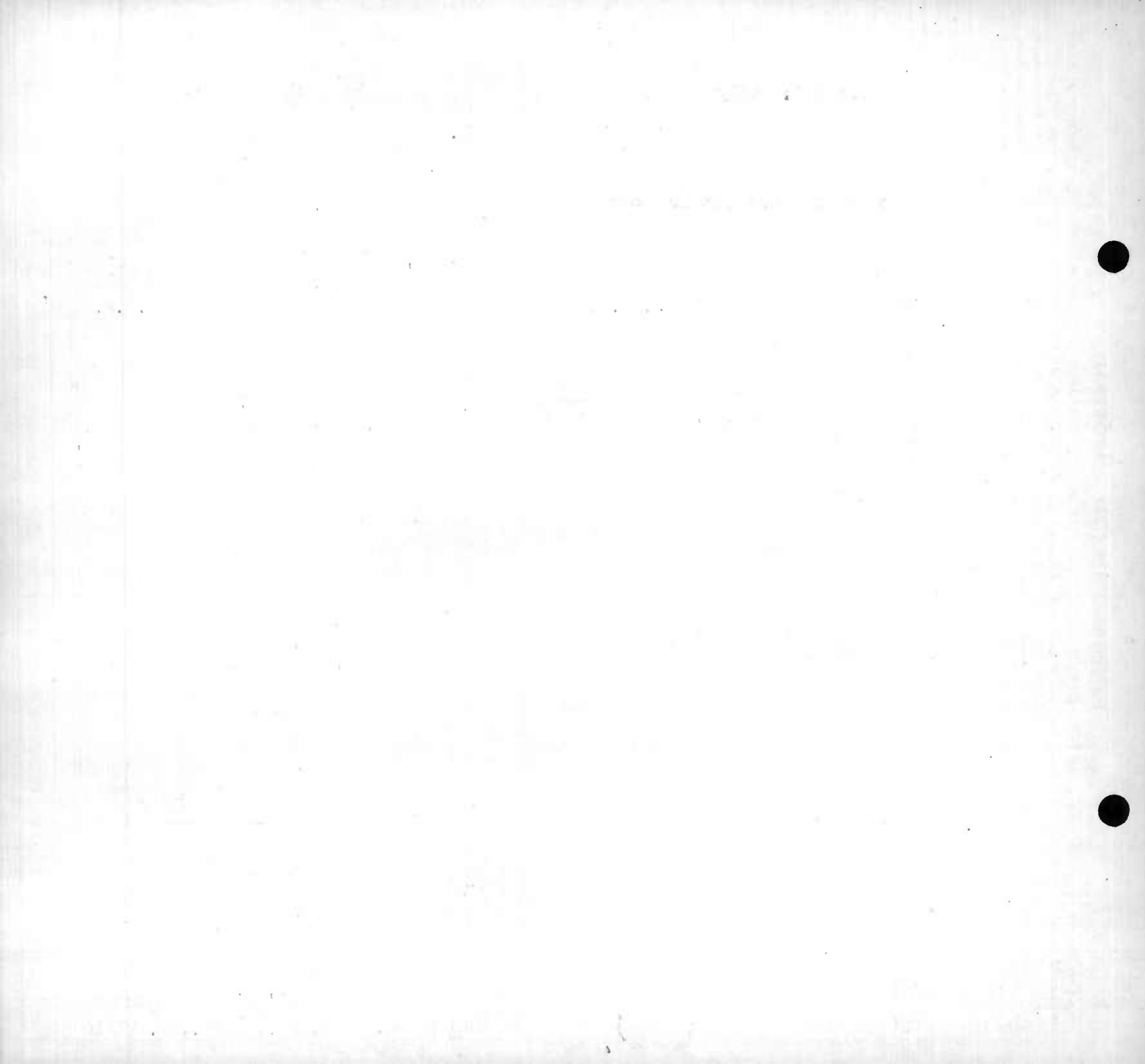
VALLEY FORCE

THE CONTENTS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

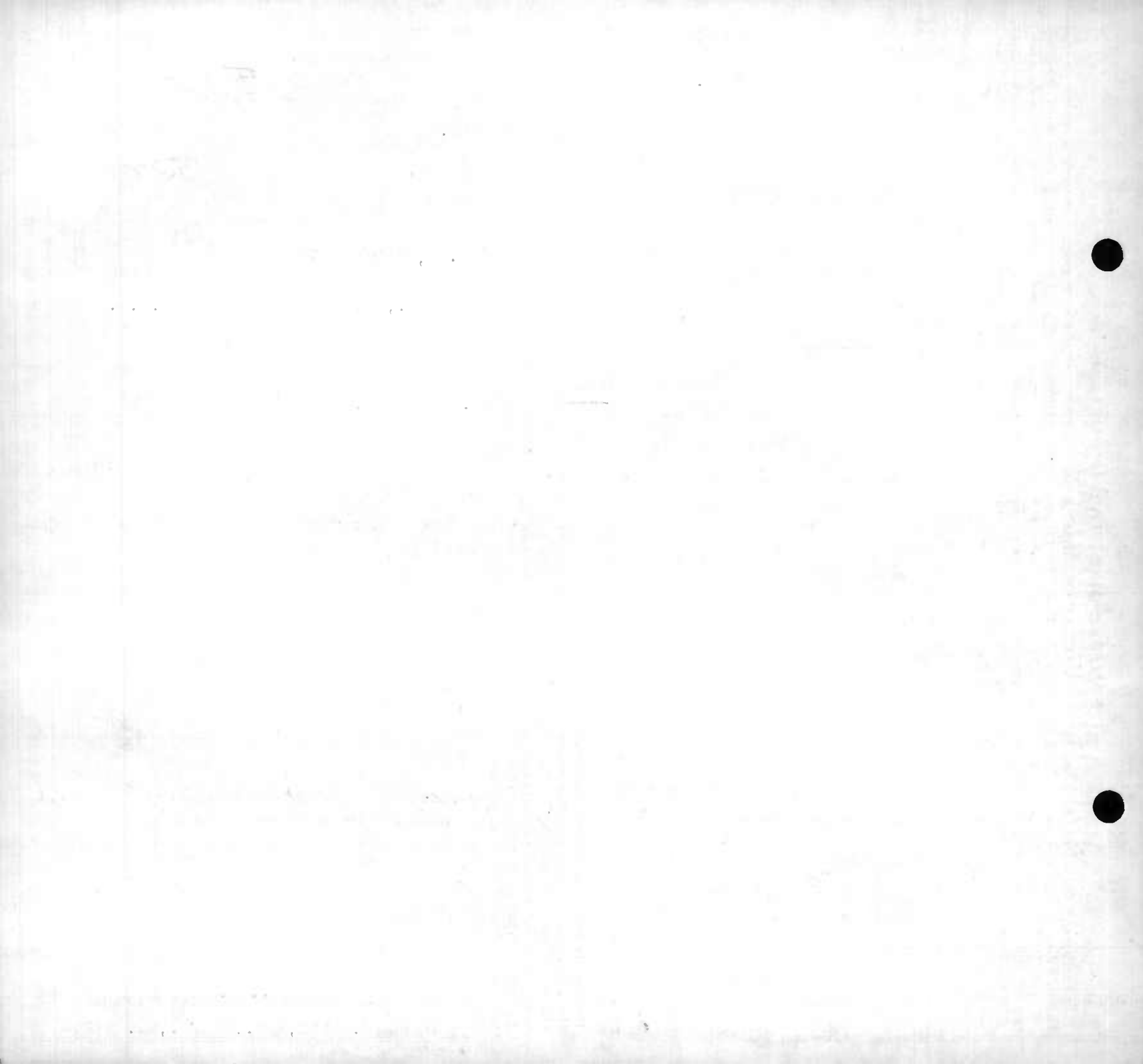
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8125	
BIRTH NO. 65 8125		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Joseph L. Kelly		2. DATE AND HOUR OF DEATH Aug 4 1965	
3. PLACE OF DEATH BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 27-38			
FULL NAME OF HOSPITAL OR INSTITUTION House in Pines Nursing Home		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.			
		D. STREET ADDRESS (If rural, give location) 1400 CEDARCROFT ROAD			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH DEC. 30, 1883	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY PENNA. R.R.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 717077189		17. INFORMANT MRS. MARGARET STROMER	
				ADDRESS SAME	
18. 420.1+1 260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Coronary Artery Disease		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH at least 8 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus				at least 8 yrs.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/31 1957 to 8/4 1965 , that (I) (we) last saw the deceased alive on 4:45 P.M. 8/4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Robert E. Farley M.D.				23B. DATE SIGNED 8/4/65	
23C. PHYSICIAN'S NAME (Type) Robert E. Farley M.D.		23D. ADDRESS 1211 NORTHERN PKWY. BALTO. 12, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/7/65		24C. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTO., MD.					
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC., BALTO., MD. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

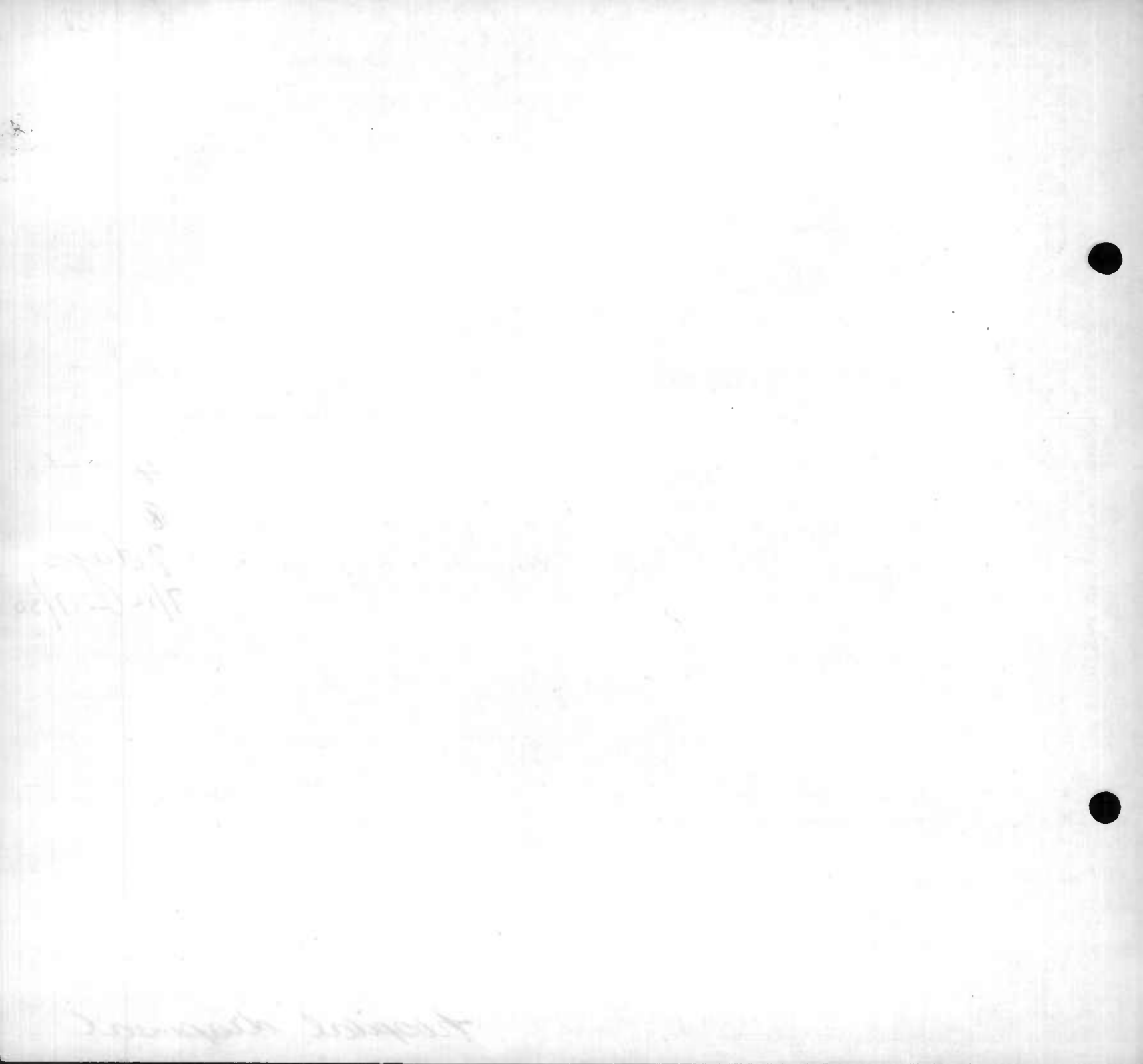
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 8126		REGISTERED NO. 65 8126	
1. NAME OF DECEASED (Type or Print) TERESA G. DERWART				2. DATE AND HOUR OF DEATH Aug 5 1965 9:15 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE GOULD CONVALESCARIUM				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MD. B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. D. STREET ADDRESS (If rural, give location) 7716 OAKLEIGH ROAD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH DEC. 2, 1886	9. AGE (In years lost birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY KINLEIN				14. MOTHER'S MAIDEN NAME DOROTHY STENGEL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ----		17. INFORMANT MR. ANDREW M. DERWART		ADDRESS SAME	
18. 722.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Cardiovascular disease				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
				(B) DUE TO		15 yrs.	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS CONTRIBUTING OR CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 19 1961 to Aug 4 1965 and that (I) (we) last saw the deceased alive on Aug 4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Per [Signature]				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/15/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/9/65		24C. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEMETERY		24D. LOCATION (City, town, or county) (State) BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1965		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC., BALTO., MD. 21214		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

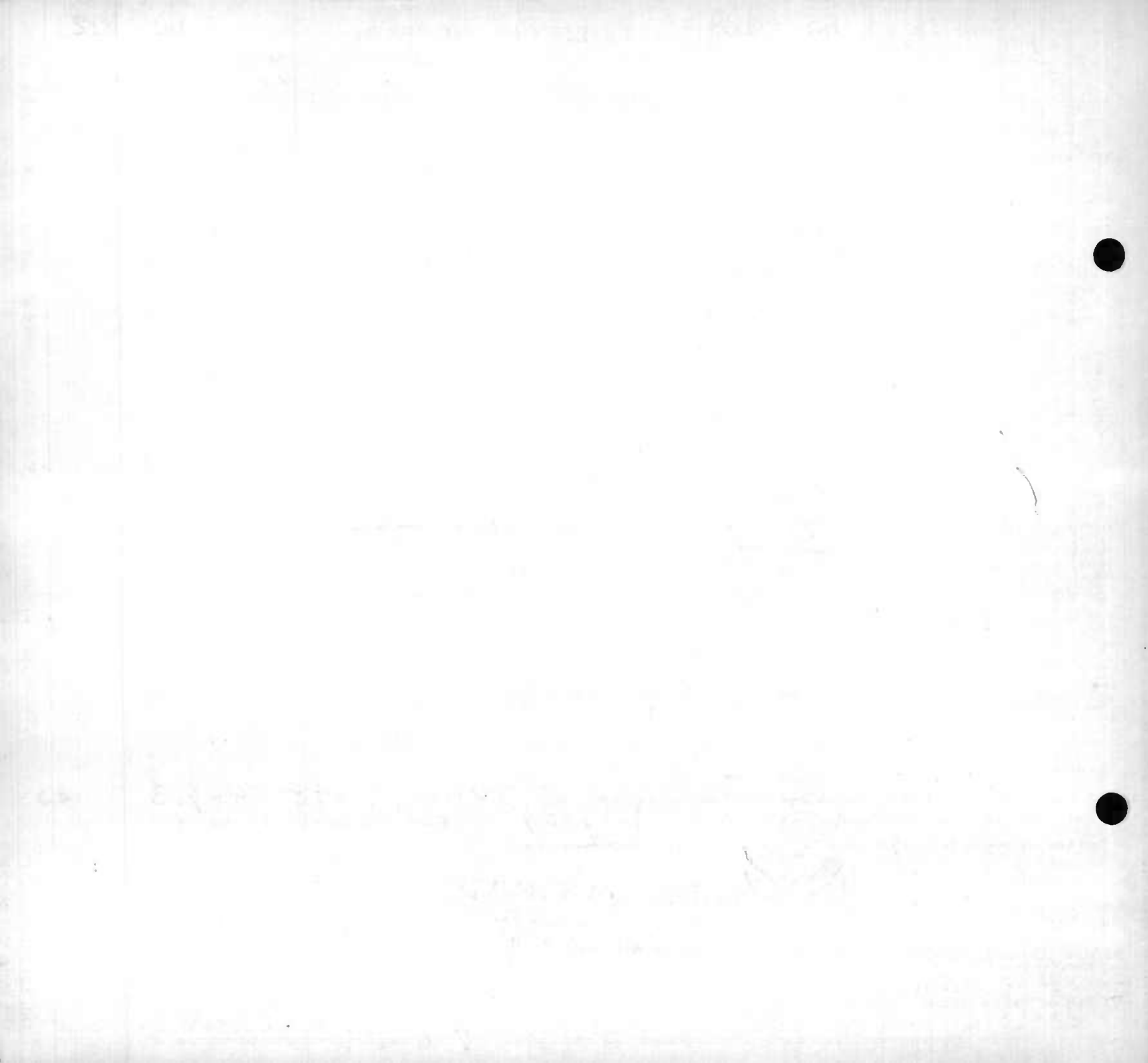
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 8127	
CERTIFICATE OF DEATH				Registered No. 65 8127	
1. NAME OF DECEASED (Type or Print) <i>Charles Anthony Jackson</i>			2. DATE AND HOUR OF DEATH <i>7-30-65 9:30 A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Franklin Square Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>9-09</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1108 E. Lanvale Street</i>		
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Never married</i>	8. DATE OF BIRTH <i>7-30-65</i>	9. AGE (In years last birthday) <i>—</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <i>— — 26</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck Driver</i>			11. BIRTHPLACE (State or foreign country) <i>Bethlehem Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>yes</i>
13. FATHER'S NAME <i>William Siles Jackson</i>			14. MOTHER'S MAIDEN NAME <i>Ethel Thelma</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT ADDRESS <i>105 E. Lanvale St</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <i>PREMATURITY</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 minutes</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Early maceration</i>			<i>8 days</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Premature rupture of membrane</i>			<i>7/22 1/30</i>		
19A. DATE OF OPERATION <i>—</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20A. AUTOPSY? (Yes or No) <i>—</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>—</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>—</i>	
21D. TIME OF INJURY (APPROX.) <i>—</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>—</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>July 9:04 AM July 30 1965</i> to <i>9:30 AM July 31 1965</i> , that (I) (we) last saw the deceased alive on <i>July 30 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Wilfredo M. Mediano</i>				23B. DATE SIGNED <i>Aug. 3, 1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>WILFREDDO M. MEDIANO</i>		23D. ADDRESS M.D. <i>FRANKLIN SQUARE HOSPITAL</i>			
24A. BURIAL CREMATION REMOVAL (Specify) <i>AUG 5 1965</i>		24B. DATE <i>AUG 5 1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>HOSPITAL DISPOSAL</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 5 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Hospital disposal</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 0420 65 8128		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 0354 8128	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) LEVEN I - CLASH		2. DATE AND HOUR OF DEATH AUG. 3 - 1965 11:21 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 2723 Fox St		A. STATE MD B. COUNTY 12-07			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 2726 Fox St.			
5. SEX M	6. RACE COI	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH FEB 15 - 1890	9. AGE (In years last birthday) 75	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER - RET.		10B. KIND OF BUSINESS OR INDUSTRY REVERE BRASS & COPPER WORKS		11. BIRTHPLACE (State or foreign country) CAMBRIDGE MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ARCHE CLASH		14. MOTHER'S MAIDEN NAME SUSAN DESHIELDS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-03-0920		17. INFORMANT FLORENCE CLASH 2726 Fox St.	
18. 443X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertensive antea. subacute cardiac disease		DUE TO		15 yrs plus	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? III in Baltimore City, give exact location	
21D. TIME OF INJURY (APPROX.) 1 Month () Day () Year () Hour ()		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1948 to Aug 3 1965 that (I) (we) last saw the deceased alive on July 29 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE RAYNER BROWNE, M.D.		23B. DATE SIGNED 8-5-65			
23C. PHYSICIAN'S NAME (Type) 1500 EAST MADISON ST. BALTIMORE, MD. 21205		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/65		24C. NAME OF CEMETERY or CREMATORY MT AUBURN	
24D. LOCATION BALTO MD		24E. NAME OF REGISTRAR Robert E. Fadden		24F. FUNERAL DIRECTOR Thos Gary Pfluger (38 N. Gilmore St)	
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1965		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
25D. ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 8129		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8129	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Willia m Leslie Armiger		Aug. 3, 1965		3:15 am M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
4814 Hamilton Avenue Baltimore 6		Md.		26-01	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
Male		White		Married	
8. DATE OF BIRTH		9. AGE (In years lost birthday)		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
13April1901		64		Salesman	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Pasadena, AA Co. Md.		USA		William T. Armiger	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Mary E. Cook		N		217-09-8498	
17. INFORMANT		18. CAUSE OF DEATH		ADDRESS	
Mrs. Bessie Armiger, same as 4		18. CAUSE OF DEATH			
		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
		(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		10 minutes	
		ANTECEDENT CAUSES		5 yrs	
		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			
		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		None	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Jan 1960 to 3rd of 1965, that (I) (we) last saw the deceased alive on July 15, 1965 and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Leon E. Kassel		8/5/65			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Leon E. Kassel, M.D.		35015 + Paul St. Bethesda Md			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/6/65		Mt. Carmel Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 6 1965		Robert E. Taylor		Kirkley Funeral Home, Glen Burnie	

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BALTIMORE CITY HEALTH DEPARTMENT				65 8130	
BIRTH NO. 65 8130		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 8130			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		HENRY HAMRICK (HAMRICK)		2. DATE AND HOUR PRONOUNCED DEAD August 4, 1965 10:40 a M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland B. COUNTY Balto	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		Baltimore 20 5300	
D. STREET ADDRESS (If rural, give location)		305 Marlyn Avenue 33 Longeron Alhve			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH Jan. 31 - 1930	9. AGE (In years last birthday) 35	10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Beth Steel Co.		Beth Steel Co.		Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Noah Hamrick		14. MOTHER'S MAIDEN NAME Adelaide Ridgley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give wat or dates of service)		16. SOCIAL SECURITY NO. 213-26-1640		17. INFORMANT Parents. Address same as above	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Multiple traumatic injuries DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Eastern Blvd west of Stuart 5300	
21D. TIME OF INJURY (APPROX.) 8 4 65 10:23a		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Operator of motorcycle which hit car	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8-4-65	
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION REMOVAL (Specify) Burial		23B. DATE Aug. 7 - 1965		23C. NAME OF CEMETERY or CREMATORY Holy Hill Cemetery	
23D. LOCATION (City, town, or county) (State) Balto Co. Md.					
24A. DATE REC'D BY HEALTH DEPT. AUG 6 1965		24B. NAME OF REGISTRAR Robert E. Finkbeiner		24C. FUNERAL DIRECTOR ADDRESS Oymally Funeral Home - 300 Grace Ave.	

VALLEY FORT

Jan 21 1930

Dear Mr. [illegible]

I have just received your letter of the 19th inst.

and am glad to hear from you.

Very truly yours,

[illegible signature]

[illegible address line 1]

[illegible address line 2]

[illegible address line 3]

[illegible address line 4]

[illegible address line 5]

[illegible address line 6]

[illegible address line 7]

[illegible address line 8]

[illegible address line 9]

[illegible address line 10]

[illegible address line 11]

[illegible address line 12]

[illegible address line 13]

[illegible address line 14]

[illegible address line 15]

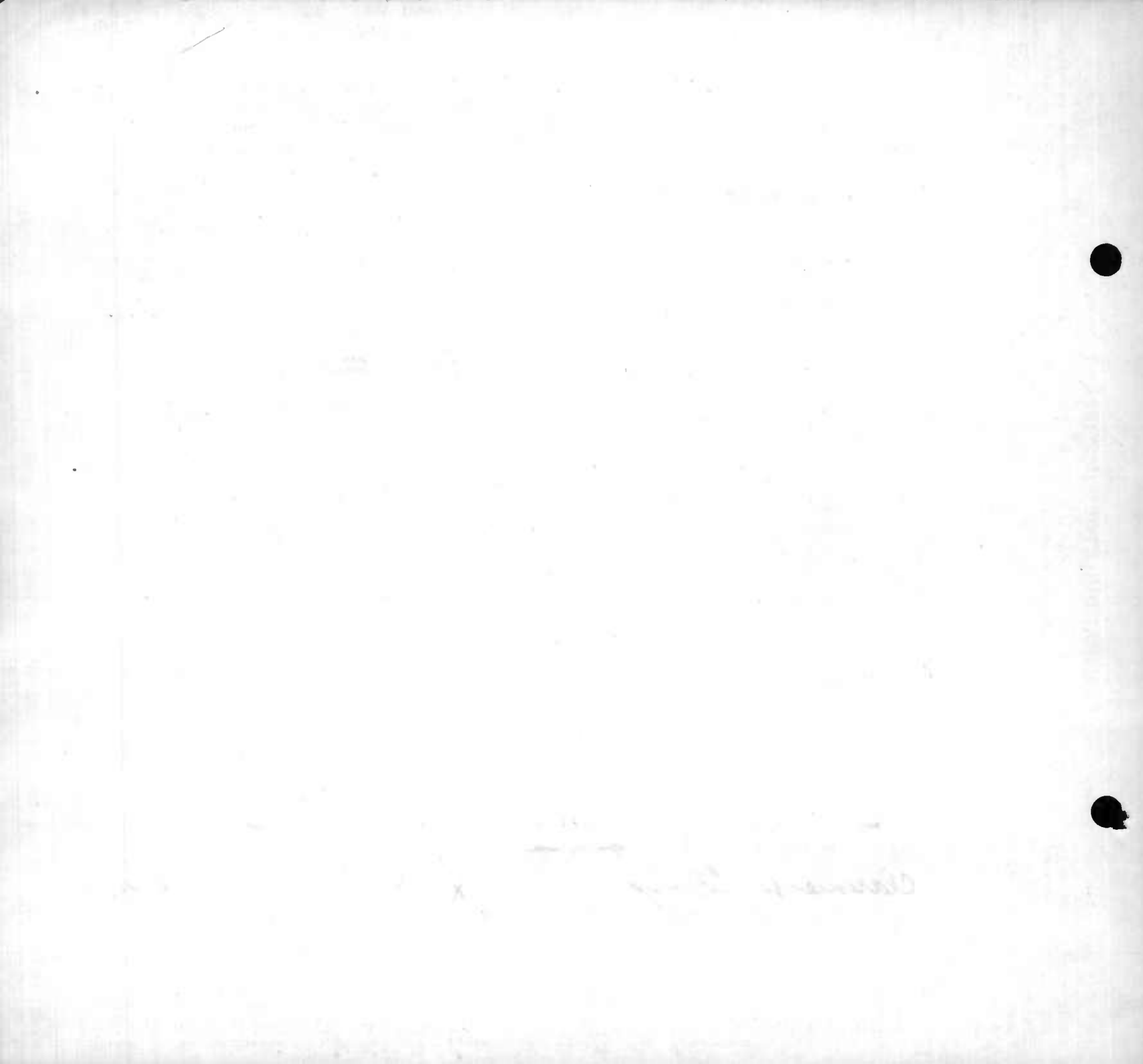
[illegible address line 16]

[illegible address line 17]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 8131	
BIRTH NO. 65 8131 M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) FREDERICK J. MORELAND, JR.		2. DATE AND HOUR OF DEATH August 3, 1965 2:35 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 603 N. Ellwood Ave.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 7-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 603 N. Ellwood Ave.	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Dec. 8, 1924
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Dept. Motor Vehicles	9. AGE (In years last birthday) 40
13. FATHER'S NAME Frederick J. Moreland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS Mrs. Julia Moreland 603 N. Ellwood Ave.	
18. 193.01 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) Astrocytoma - right cerebral hemisphere DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION May 1963		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Brain tumor	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 1963 to August 1965 , that (I) (we) last saw the deceased alive on August 3 1965 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Clarence W. LeDoit		23B. DATE SIGNED 8/4/65	
23C. PHYSICIAN'S NAME (Type) Clarence W. LeDoit		23D. ADDRESS 3023 Eastern Ave.	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 8/6/65	
24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1965		25B. NAME OF REGISTRAR Robert E. Fadden	
25C. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road.		ADDRESS	



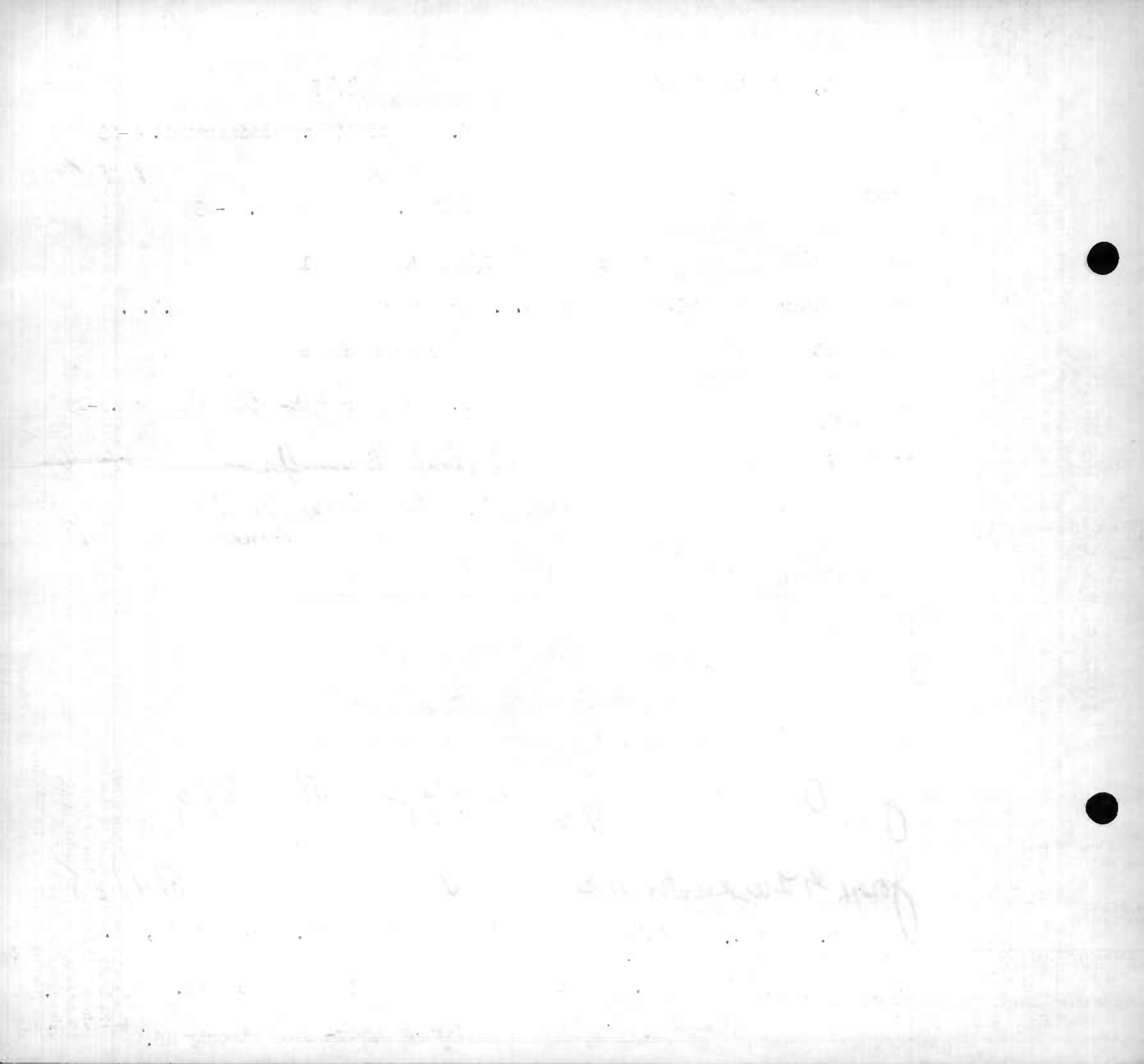
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65 8132		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No. 65 8132	
BIRTH NO. M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)			
JAMES BASILE				2. DATE AND HOUR PRONOUNCED DEAD August 4, 1965 11:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3023 Spaulding Avenue			
5. SEX Male		6. RACE Caucasian		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH ABOUT 9/14/1893	
9. AGE (In years last birthday) ABOUT 71		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		11. BIRTHPLACE (State or foreign country) Sicily		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 216-09-7584		17. INFORMANT Mrs. Margaret Basile, 3023 Spaulding Ave.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) Arteriosclerotic Cardiovascular Disease. DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Charles S. Petty, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8/5/65	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 8/9/65		23C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		23D. LOCATION (City, town, or county) (State) Baltimore, Md.	
24A. DATE REC'D BY HEALTH DEPT. AUG 6 1965		24B. NAME OF REGISTRAR Robert E. Farley		24C. FUNERAL DIRECTOR L. Vernon Leman		ADDRESS 4611 Park Heights Ave.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

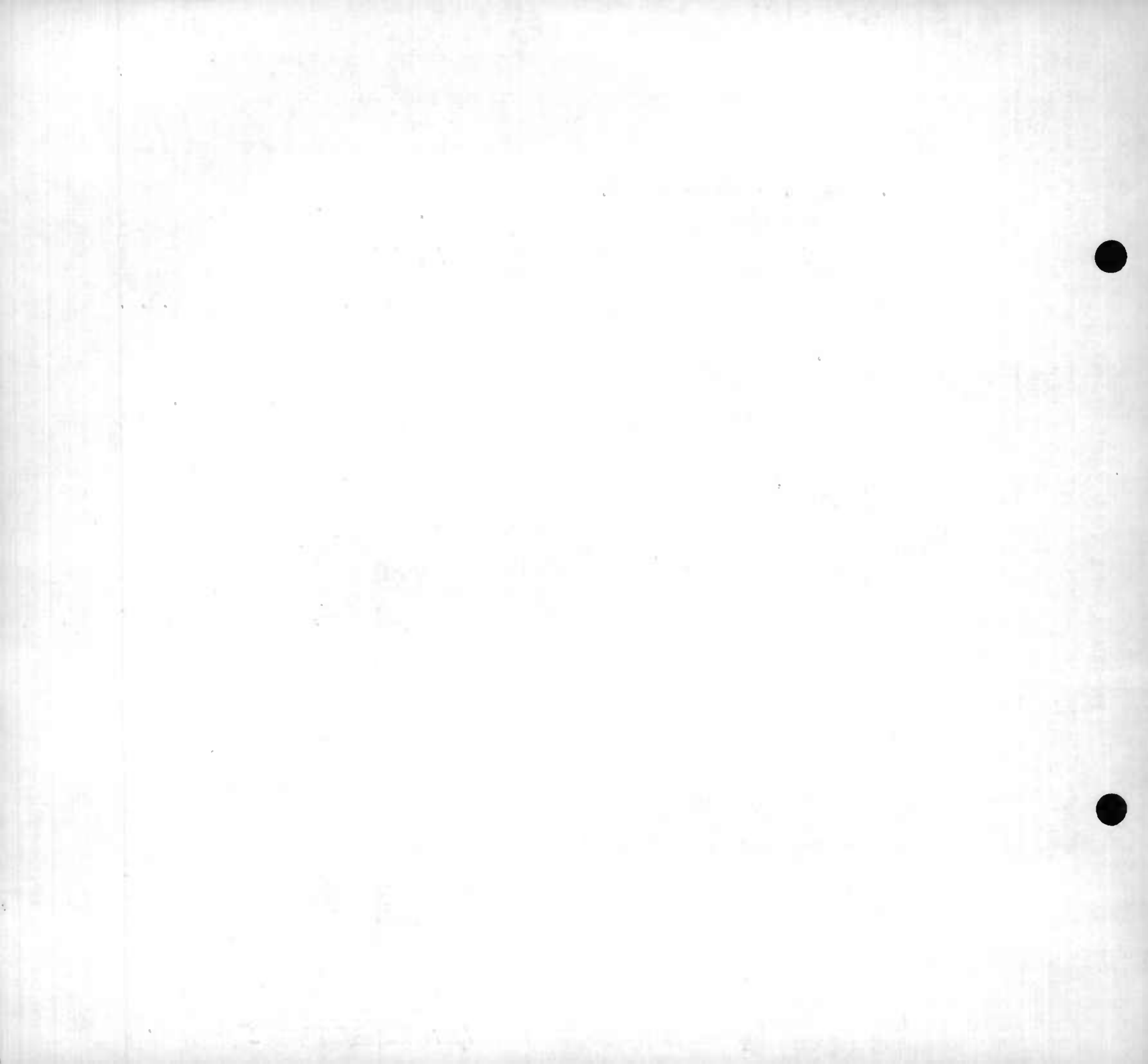
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 8133		CERTIFICATE OF DEATH		Registered No. 65 8133		
1. NAME OF DECEASED (Type or Print) Bast, Phillip Edward				2. DATE AND HOUR OF DEATH 8/3/65 11:30 a M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Haven Nursing Home				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1817 W. Baltimore St., No. 23 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1817 W. Baltimore St. -23 79--04						
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 1/8/1884	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fuel Inspector			10B. KIND OF BUSINESS OR INDUSTRY Delaware Hudson E.R.			11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Bast				14. MOTHER'S MAIDEN NAME Margaret Schade						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Alexander Bast- 4304 Belle Ave. -15				ADDRESS	
18. 442X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO Cerebral Hemorrhage (B) DUE TO Arterio Sclerotic Cardiovascular and Brain (C) _____				INTERVAL BETWEEN ONSET AND DEATH 81/65 10 yrs		
MEDICAL CERTIFICATION										
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from 10-14-58 to 8/3-65 , that (I) (we) last saw the deceased alive on 8/3-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Joseph G. Laukaitis MD				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/4/65				
23C. PHYSICIAN'S NAME (Type) Dr. Joseph G. Laukaitis				23D. ADDRESS 4406 Garrison Blvd. Baltimore 15, Md.						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/5/65		24C. NAME of CEMETERY or CREMATORY Mt. Olivet		24D. LOCATION (City, town, or county) (State) 2930 Frederick Ave. Baltimore MD				
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1965		25B. NAME OF REGISTRAR Robert E. Fisher, MA		25C. FUNERAL DIRECTOR Loring Byers, 2728 Liberty Rd. Randallstown						



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8134	
BIRTH NO. 65 8134		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Marie May Gosnell</i>		2. DATE AND HOUR OF DEATH <i>August 3, 1965 9:40 PM</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>908 N. Port St. - Baltimore, Md.</i>			A. STATE <i>Maryland</i> B. COUNTY <i>7-02</i>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		
			D. STREET ADDRESS (If rural, give location) <i>908 N. Port Street</i>		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Never married</i>	8. DATE OF BIRTH <i>May 14, 1926</i>	9. AGE (In years last birthday) <i>39</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>none</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Charles R. Gosnell</i>			14. MOTHER'S MAIDEN NAME <i>Victoria Gall</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Family</i>		ADDRESS <i>908 N. Port St.</i>
18. 0334 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Broncho-Pneumonia</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Septicemia</i>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>1 mo.</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Probable Pituitary Tumor about 20 yrs.</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10/26</i> 19 <i>35</i> to <i>Aug 3</i> 1965, that (I) (we) last saw the deceased alive on <i>Aug 3</i> 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death.					
23A. SIGNATURE <i>Louis F. Klimes</i>				23B. DATE SIGNED <i>8/3/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>LOUIS F. KLIMES</i>				23D. ADDRESS <i>2623 E. Monument St</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/6/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Oak Hill</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 6 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR <i>Rosedale Funeral Home-Philip E. Cvach</i>	
				ADDRESS <i>5116 Calhoun Avenue - 21206</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8135	
BIRTH NO. 65 8135		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Keyser, Irvin SIDNEY		2. DATE AND HOUR OF DEATH 8/4/65 12 ⁵⁵ /AM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
CERTIFICATE AMENDED 8/16/65 FULL NAME OF HOSPITAL OR INSTITUTION SINAI Hospital of Balt., Inc. ADDRESS OR LOCATION		A. STATE Md B. COUNTY Balto			
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH JUNE 27, 1923		9. AGE (In years) 42		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESIDENT		10B. KIND OF BUSINESS OR INDUSTRY BANK		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ISAAC KEYSER		14. MOTHER'S MAIDEN NAME MOLLIE ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW 2 ARMY		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS. RUTH ANN KEYSER 9 SPRINGBRIAR LANE	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Acute myocardial infarction DUE TO (B) ASCVD DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3-4 hrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/3/65 19 to 8/4/65 19 that (I) (we) last saw the deceased alive on 8/3/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE HARRY TABOR		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/24/65	
23C. PHYSICIAN'S NAME (Type) HARRY TABOR		23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/5/65		24C. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW	
24D. LOCATION REISTERSTOWN, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. AUG 6 1965			
25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN			

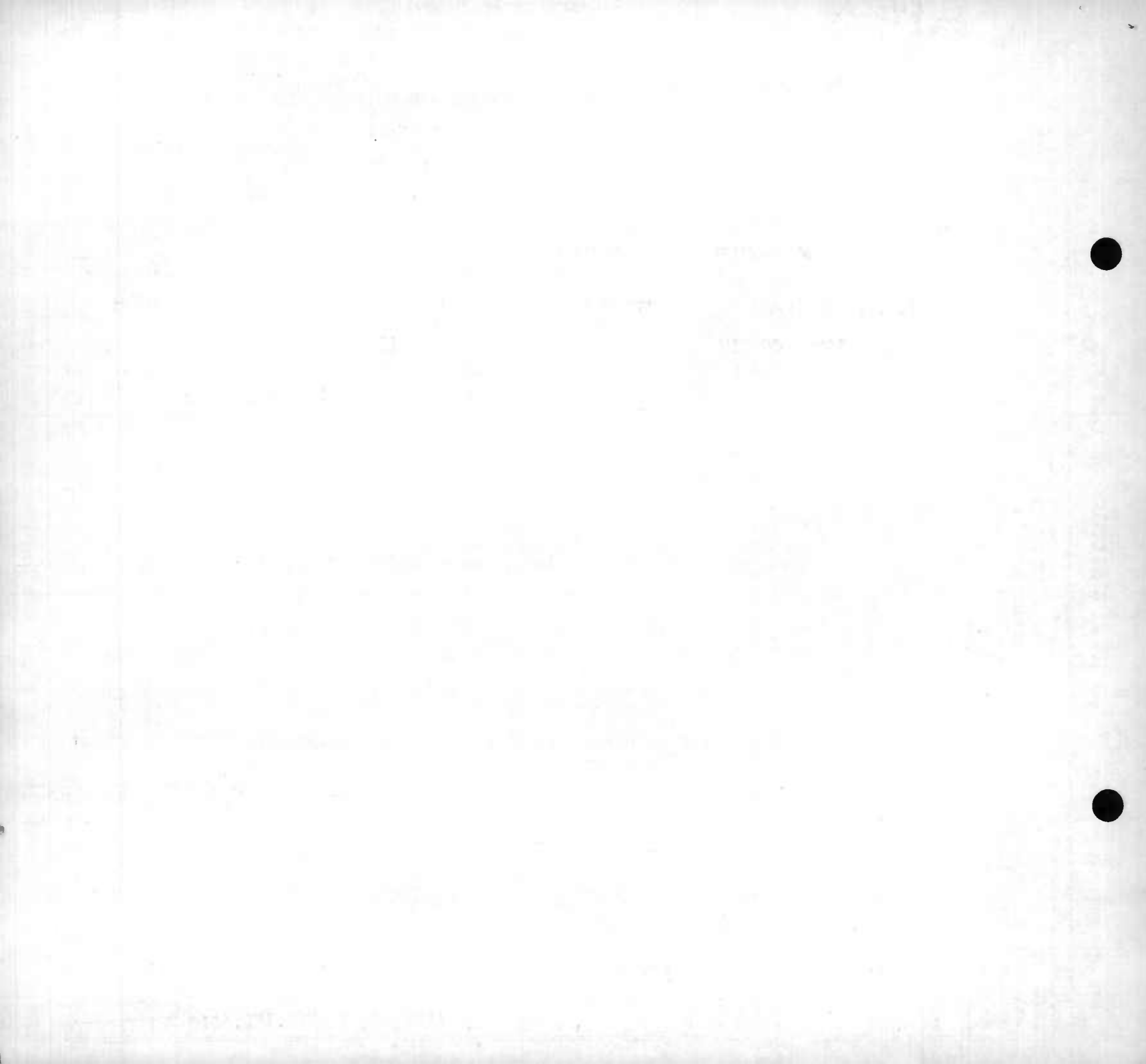
letter from Sinai Hospital /sg/n/ signed by Evelyn M. Carter. Medical Records.

8/16/65 C. Bowens

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

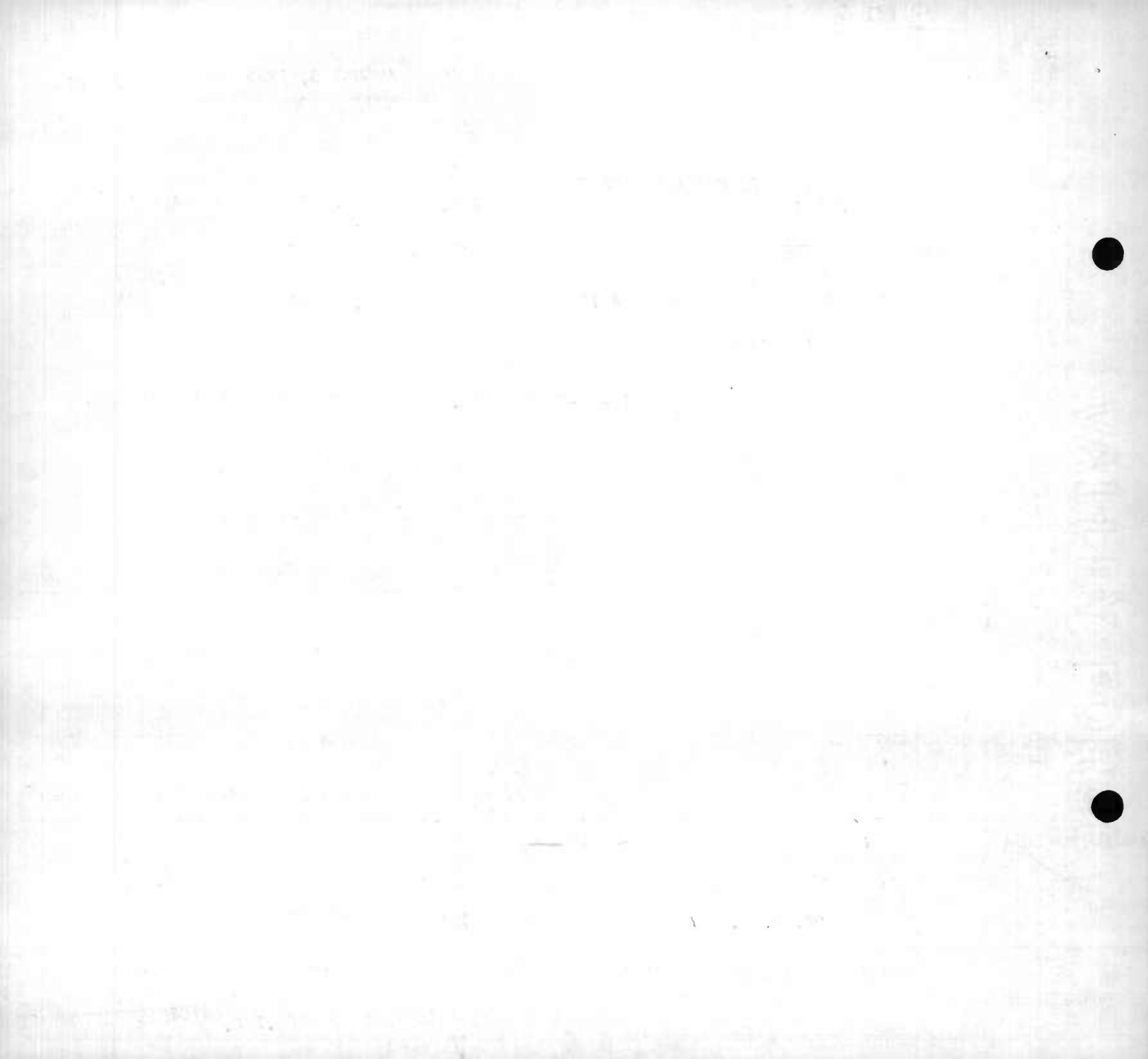
C 640 65 8136		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8136	
BIRTH NO. 65 8136		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Charlow, Sophie		2. DATE AND HOUR OF DEATH 4 Aug 65 3:50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-20			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSP OF BALTO, INC.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 3901 LABYRINTH ROAD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11/20/1892	9. AGE (In years lost birthday) 72	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired H/W		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) Balto, Md	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JAMES COPLIN		14. MOTHER'S MAIDEN NAME LENA ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Harry M. WALLEN MD	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory arrest		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 34 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral vascular accident		(B) DUE TO			
		(C) Arteriosclerosis & hypertension unknown			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Urinary tract infection					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/30/65 to 8/4/1965 , that (I) (we) last saw the deceased alive on 8/4/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harry M. Wallen		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4 Aug 65	
23C. PHYSICIAN'S NAME (Type) HARRY M. WALLEN		23D. ADDRESS 5356 Carriage Ct. Balto, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/5/65		24C. NAME OF CEMETERY or CREMATORY AITZ CHAIM	
24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC.	
				ADDRESS 6010 REISTERSTOWN RD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

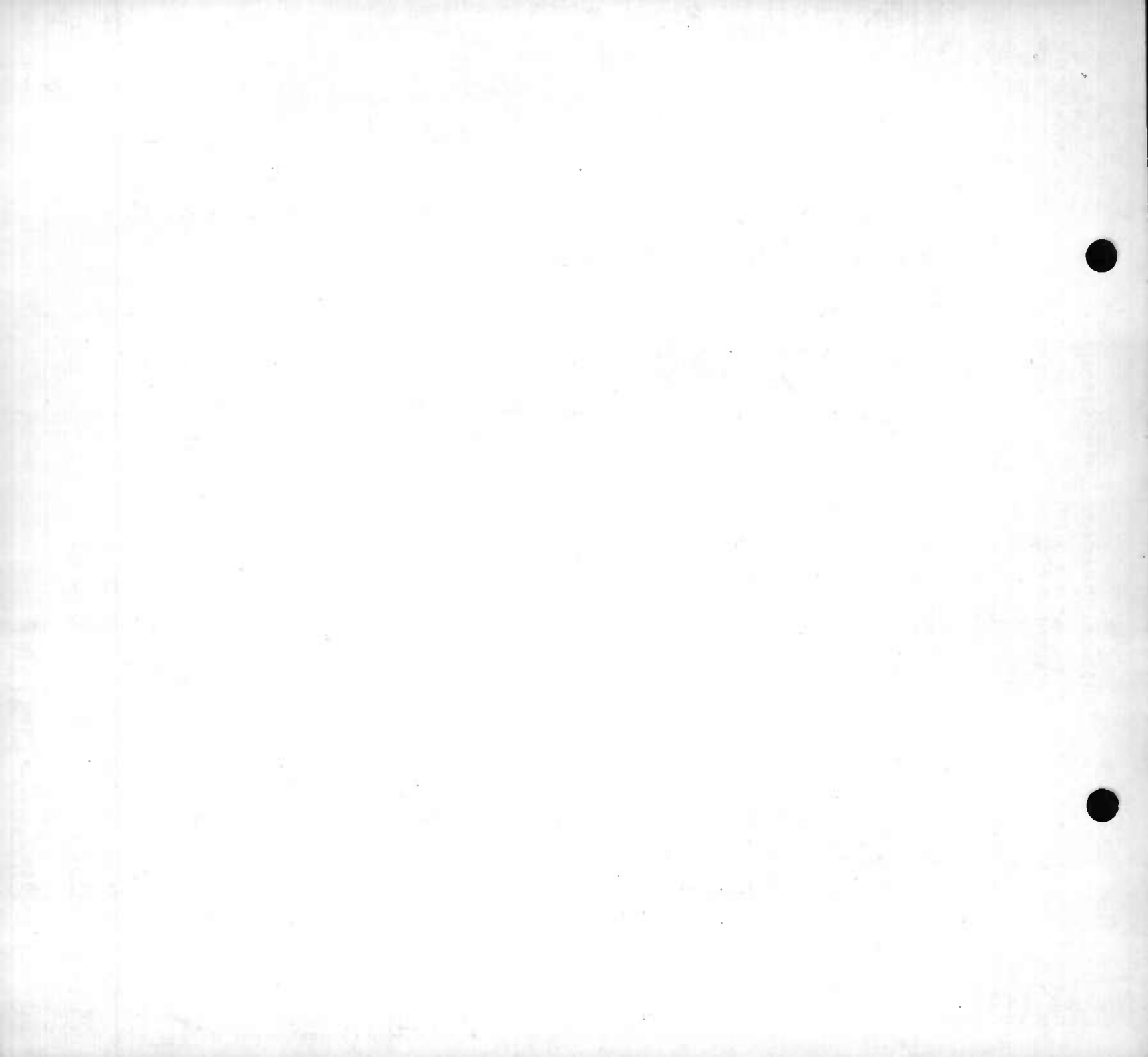
BIRTH NO. 812065		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8137	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FRANK SAVAGE			2. DATE AND HOUR OF DEATH AUGUST 3, 1965		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1203 NORTH CHARLES STREET APT 1E			A. STATE MARYLAND B. COUNTY 11-02		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 1203 NORTH CHARLES STREET APT 1E		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 5/30/1895	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER		10B. KIND OF BUSINESS OR INDUSTRY BURKE SAVATIRE CO	11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME CHARLES SAVAGE			14. MOTHER'S MAIDEN NAME ANNA ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-05-7469	17. INFORMANT ADDRESS MRS. HARRY BEATY 2606 VIOLET AVENUE		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CORONARY OCCLUSION			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			(A) DUE TO (B) DUE TO (C) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov 7 1953 to Aug 3 1965 , that (I) (we) last saw the deceased alive on Aug 2 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. P. Friedman				23B. DATE SIGNED 8/4/65	
23C. PHYSICIAN'S NAME (Type) DR. H. P. FRIEDMAN		23D. ADDRESS 1319 LIGHT STREET			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/4/65		24C. NAME OF CEMETERY or CREMATORY BALTIMORE HEBREW	
24D. LOCATION BALTIMORE		24E. LOCATION (City, town, or county) (State) MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1965		25B. NAME OF REGISTRAR Robert E. Fairley		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. K 65 32 8138		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8138	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Sadie NMN Pasatchkoff		2. DATE AND HOUR OF DEATH 8-5-65 5:25 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 27-20			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Hospital For The Women of Md.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3801 Fordley Rd.			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 3-27-1893	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY AT Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Fred NMN Wallenstein		14. MOTHER'S MAIDEN NAME Baumgarten, Carrie	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Patients chart	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 260X I		CAUSE OF DEATH Ruptured heart secondary to myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO hypertension			
		(B) DUE TO cholesterol metabolism			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-3 19 65 to 8-5 19 65 , that (I) (we) lost saw the deceased alive on 8-5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Henni E. Voorstad		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8.5.65	
23C. PHYSICIAN'S NAME (Type) H.T. VOORSTAD		23D. ADDRESS M.D. 6321 N. CHARLES ST. BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/6/65		24C. NAME OF CEMETERY or CREMATORY Baltimore Hebrew	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland					
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Phyllis G. ... & Son Inc 600 Reisterstown Rd.	



BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 8139

1. NAME OF DECEASED
(Type or Print)

PAUL

UMASKY

2. DATE AND HOUR PRONOUNCED DEAD

August 4, 1965

8:10 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5343 Gist Avenue

5. SEX

Male

6. RACE

Caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MANAGER

10B. KIND OF BUSINESS OR INDUSTRY

MEAT

11. BIRTHPLACE (State or foreign country)

RUSSIA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

BENJAMIN UMANSKY

14. MOTHER'S MAIDEN NAME

RACHAEL ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

MRS. PEARL UMANSKY 5343 GIST AVENUE

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
(If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petry, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/5/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

8/6/65

23C. NAME of CEMETERY or CREMATORY

CHIZUK AMUNO

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

AUG 6

1965

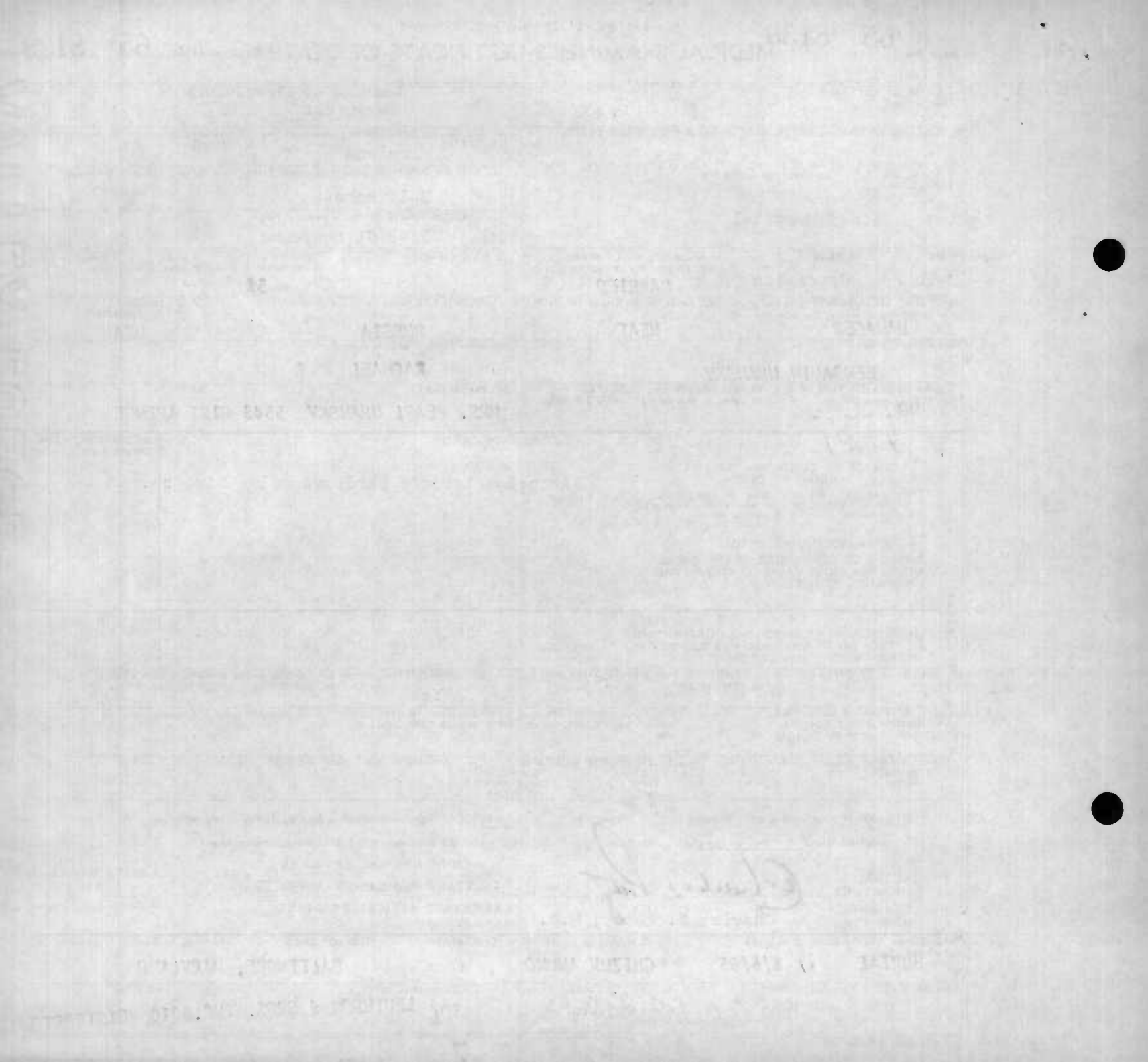
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN

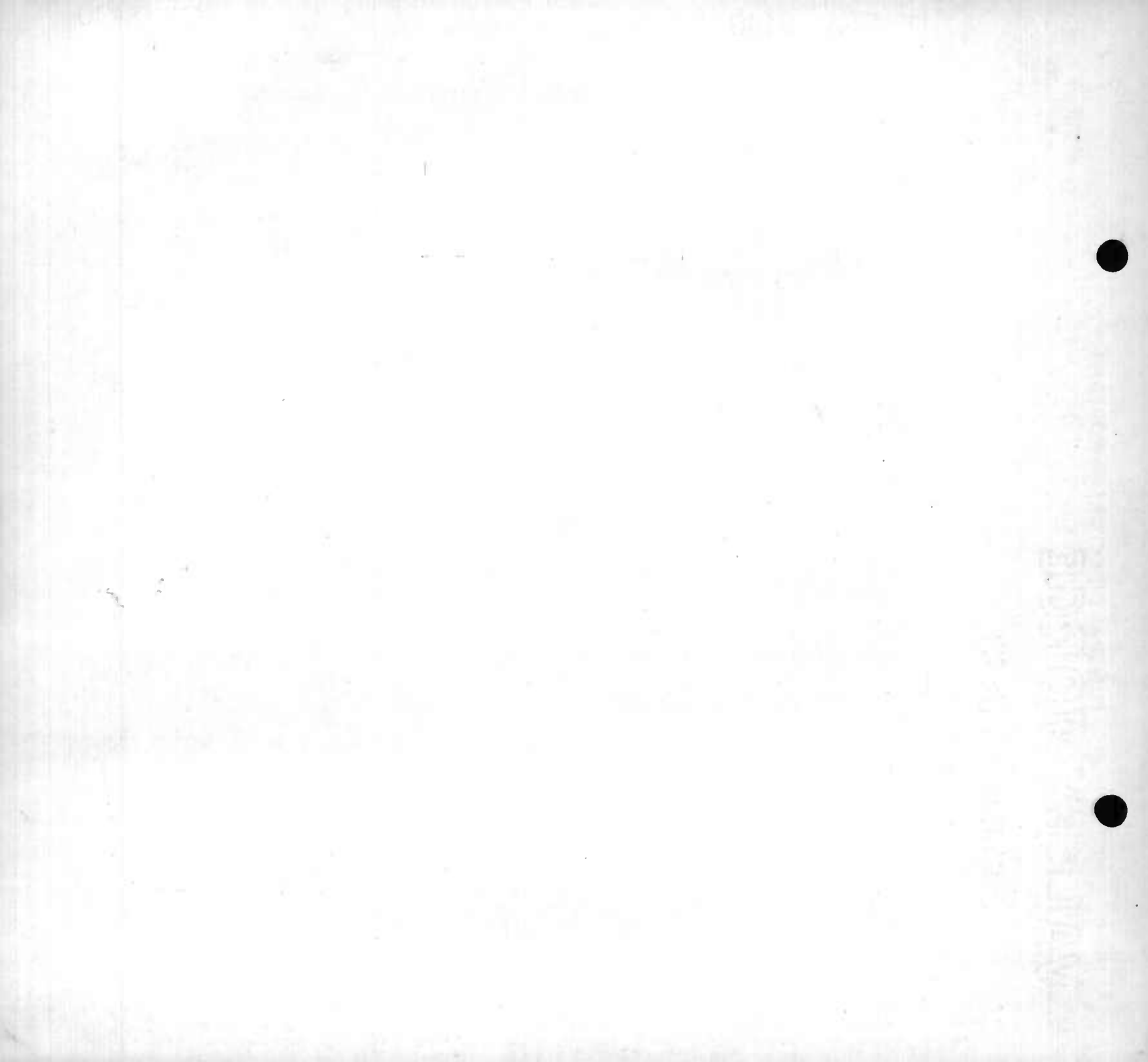
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

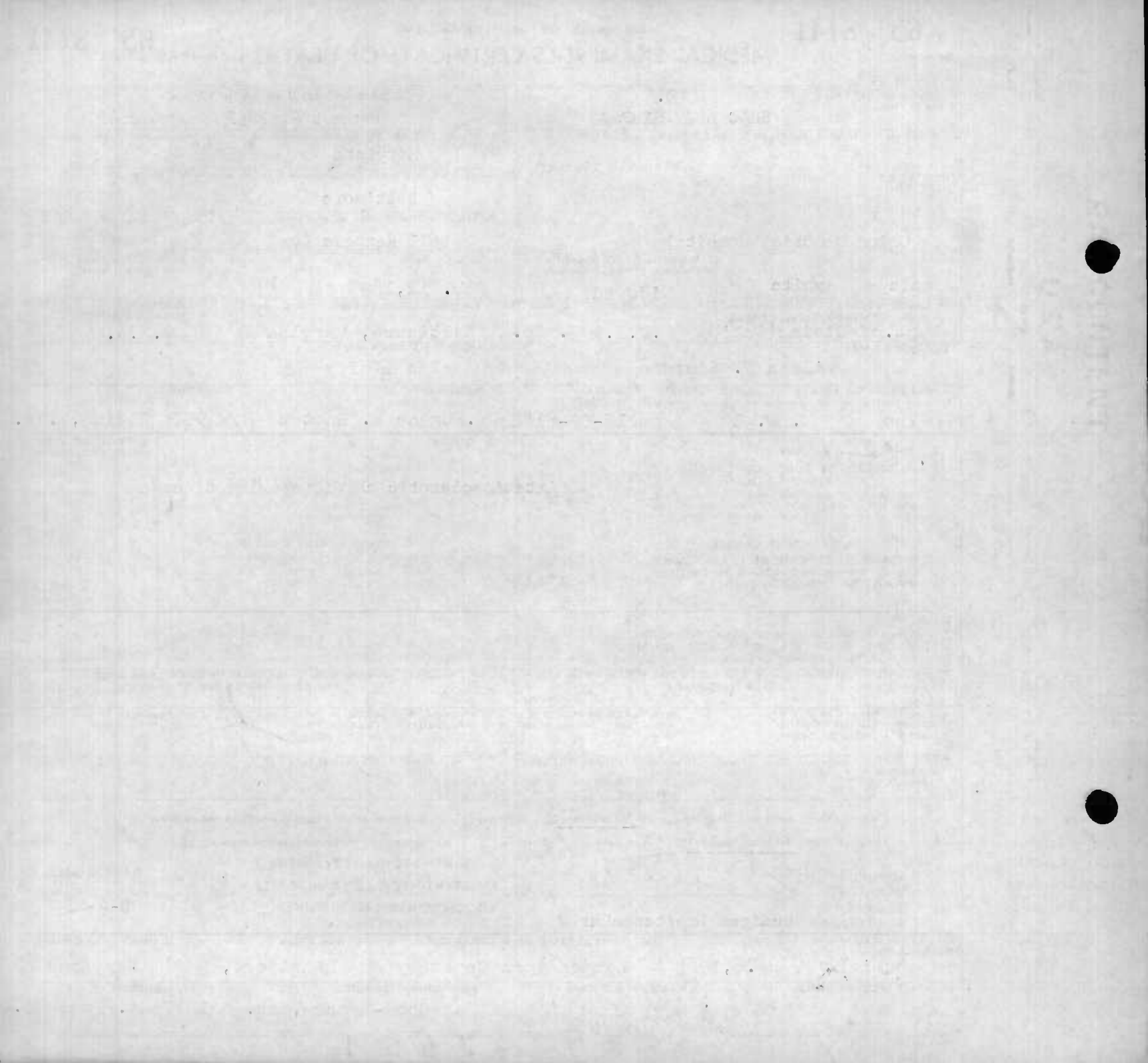
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8140	
BIRTH NO. 65 8140		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Ernest Gardner		2. DATE AND HOUR OF DEATH 8-5-65 1 8:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 14-03			
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 2012 MADISON AVENUE			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 10-17-02	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) M.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME HENRY GARDNER			14. MOTHER'S MAIDEN NAME EMMA SUTTON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. 214-44-4691		17. INFORMANT James W. Gardner 341 Gates Ave	
18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Adenocarcinoma		CAUSE OF DEATH (A) Adenocarcinoma DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 month	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 28 19 65 to August 5 19 65 , that (I) (we) last saw the deceased alive on August 5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas M. Zizic M.D.				23B. DATE SIGNED 8-5-65	
23C. PHYSICIAN'S NAME (Type) Thomas M. Zizic M.D.		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug 9-65		24C. NAME OF CEMETERY or CREMATORY Brown Hill am	
				24D. LOCATION (City, town, or county) (State) Greenville N.C.	
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR W. S. Nelson, 1348 N. Calhoun St	



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S 512

65 8141		BALTIMORE CITY HEALTH DEPARTMENT		65 8141	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		D. SHACKLETT SIMPSON		2. DATE AND HOUR PRONOUNCED DEAD August 4, 1965 8:45 a M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland		B. COUNTY 9-03	
Union Memorial Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 3611 Rexmere Road	
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Feb. 12, 1895	9. AGE (In years last birthday) 70	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. of Claims (Ret'd)		10B. KIND OF BUSINESS OR INDUSTRY U.S.F. & G. Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Wilson N. Simpson		14. MOTHER'S MAIDEN NAME Ida B Ruffy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) Yes W. W. 1		16. SOCIAL SECURITY NO. 215-07-8182		17. INFORMANT Dr. Eugene E. Hutton	
		ADDRESS Box 512 Elkins, W. Va.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(A) Arteriosclerotic cardiovascular disease DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE Aug. 6, 1965		23C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
23D. LOCATION (City, town, or county) (State) Baltimore, Maryland		24A. DATE REC'D BY HEALTH DEPT. AUG 6 1965		24B. NAME OF REGISTRAR Robert E. Farley M.D.	
24C. FUNERAL DIRECTOR Wm Cook-Brooks, Inc.		24D. ADDRESS 1217 St. Paul St.			



65 8142

BALTIMORE CITY HEALTH DEPARTMENT

65 8142

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SOLOMON

DAVIS

2. DATE AND HOUR PRONOUNCED DEAD

August 4, 1965

12:50 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

19-02

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

118 N. Mount Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SEPARATED

8. DATE OF BIRTH

9/1/42

9. AGE (In years
last birthday)

22

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

WILLIE R DAVIS

14. MOTHER'S MAIDEN NAME

ALBERTA RODES

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

MRS ALBERTA DAVIS 118 N Mount St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Status Epilepticus
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Scarring of Cerebral Cortex.
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/5/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/9/65

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

A A County Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 6 1965

Robert E. Farkas, M.D.

Adolphus Halstead 1206 W North Ave

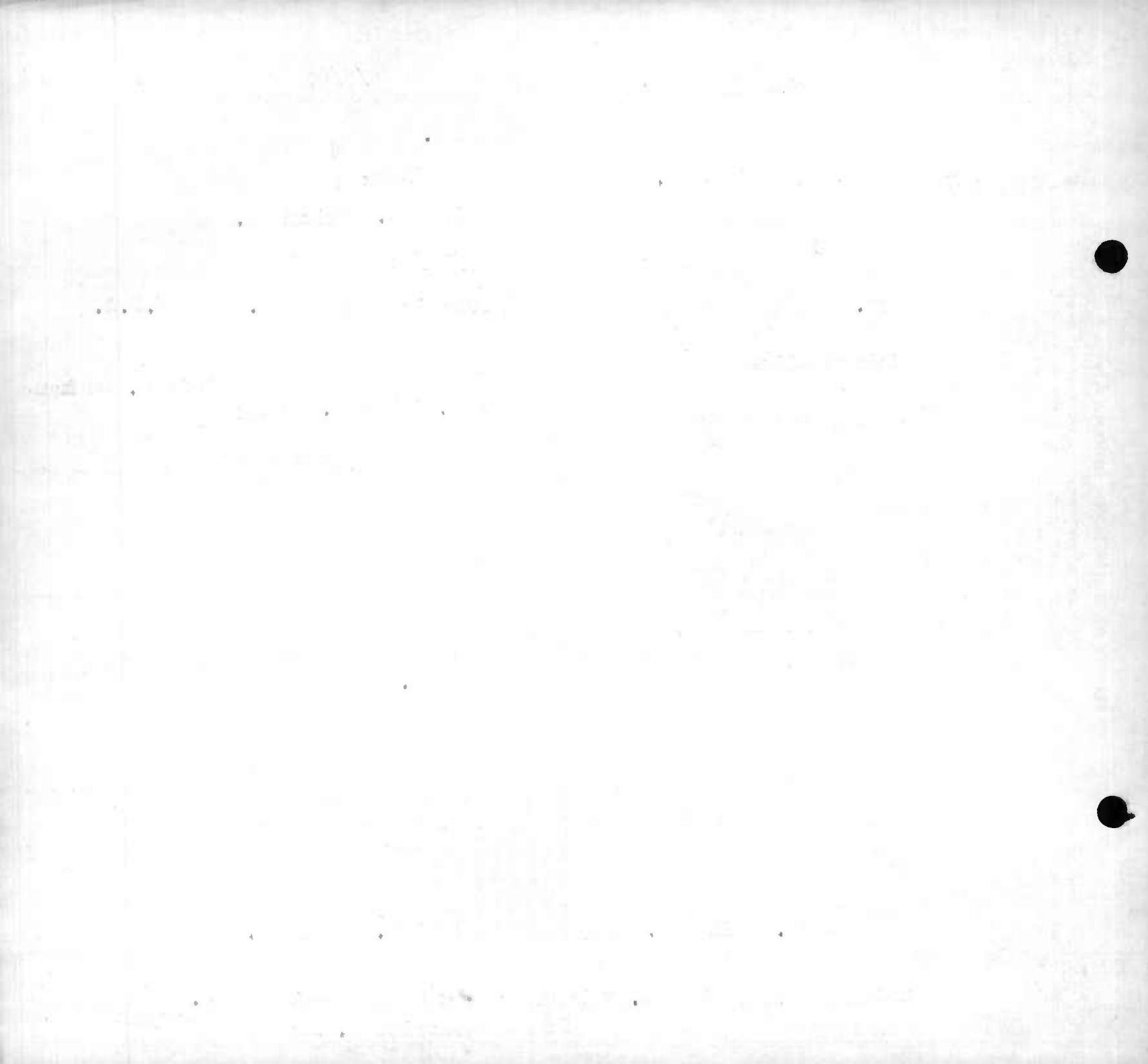
WALTER H. SMITH

Charles J. Smith

FUNERAL DIRECTOR: IMPORTANT

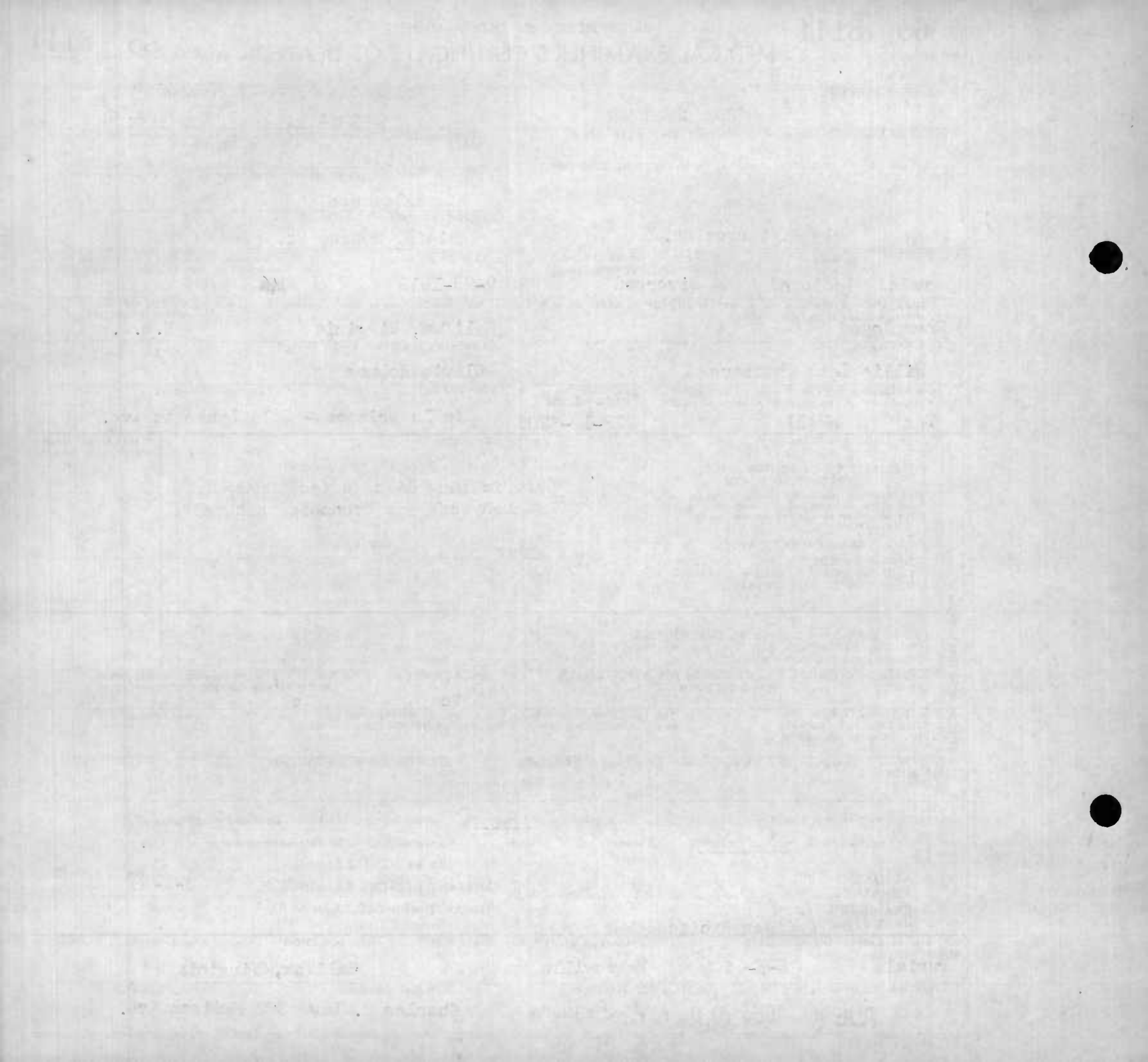
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8143		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8143	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) John Allen		2. DATE AND HOUR OF DEATH 8/5/65		5:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY		8-06	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1625n Durham ST.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If not in city limits, give location). 1625 N. Durham ST.	
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 5/18/94	9. AGE (in years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Freericksburg VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Richard Allen		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Doris M. Frisby	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) Arterio sclerotic Heart Disease		CAUSE OF DEATH DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1960 to 1965 that (I) last saw the deceased alive on 8/1 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE DR. Dudley C. Lee		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) DR. Dudley C. Lee		23D. ADDRESS 1501 E. Eager ST.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/10/65		24C. NAME OF CEMETERY or CREMATORY Auburn Crematory	
24D. LOCATION (City, town, or county) (State) Baltimore MD.		25A. DATE RECD BY HEALTH DEPT. AUG 6 1965			
25B. NAME OF REGISTRAR Charles R. Law		25C. FUNERAL DIRECTOR 802 Madison			



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C 516

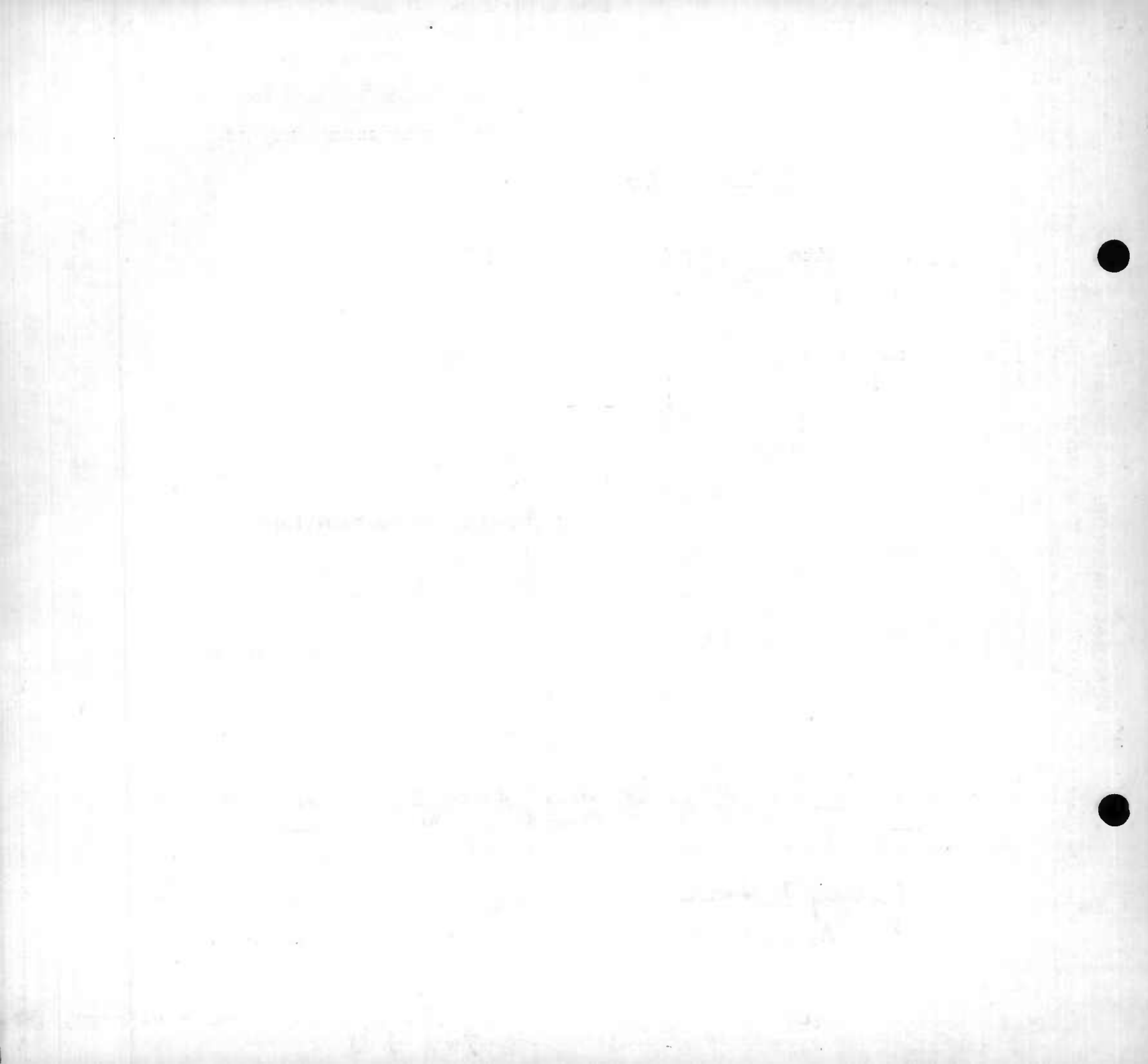
65 8144		BALTIMORE CITY HEALTH DEPARTMENT		65 8144	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		MAJOR CHAMBERS		2. DATE AND HOUR PRONOUNCED DEAD August 4, 1965 8:30 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		B. COUNTY 16-04 Baltimore	
824 N. Monroe St.		D. STREET ADDRESS (If rural, give location)		824 N. Monroe St.	
5. SEX male	6. RACE colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 9-23-1918	9. AGE (In years last birthday) 46	10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Halifax, Virginia	
13. FATHER'S NAME Willie Less Chambers		14. MOTHER'S MAIDEN NAME Olivia Holmes		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 228-10-5208		17. INFORMANT ADDRESS Stella Grissom - 2615 Lauretta Ave.	
18. 527.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Chronic lung disease (pulmonary emphysema and bronchial asthma)		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8-4-65	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 8-8-65		23C. NAME OF CEMETERY or CREMATORY Meadsville	
24A. DATE REC'D BY HEALTH DEPT. AUG 6 1965		24B. NAME OF REGISTRAR Robert E. Farley, M.D.		24C. FUNERAL DIRECTOR ADDRESS Charles R. Law 802 Madison Ave.	
24D. LOCATION (City, town, or county) (State) Halifax, Virginia					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8145	
BIRTH NO. 65 8145		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 8-4-65 7:15 A.M.	
1. NAME OF DECEASED (Type or Print) GILBERT LEE COLE			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Washington C. CITY OR TOWN (If outside city limits, write RURAL and give township) Sandy Hook D. STREET ADDRESS (If rural, give location) Main Street	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/9/09
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman		10B. KIND OF BUSINESS OR INDUSTRY Railroad	9. AGE (In years last birthday) 56
11. BIRTHPLACE (State or foreign country) Sandy Hook, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Howard Cole		14. MOTHER'S MAIDEN NAME Rosie Marshall	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-09-9440	17. INFORMANT ADDRESS Mrs. Louise V. Cole R.F.D.#2, Knoxville, Md.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 204.31		CAUSE OF DEATH (A) SEPSIS DUE TO (B) ACUTE LEUKEMIA DUE TO (C) _____	
INTERVAL BETWEEN ONSET AND DEATH 2-3 WKS.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from AUG 3 19 65 to AUG 4 19 65 , that (I) (we) last saw the deceased alive on AUG 4 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Ashley T. Haase		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 8/4/65
23C. PHYSICIAN'S NAME (Type) ASHLEY T. HAASE		23D. ADDRESS 40 JOHNS HOPKINS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/7/65	24C. NAME of CEMETERY or CREMATORY New Brethren Cemetery	24D. LOCATION (City, town, or county) (State) Brownsville, Maryland
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1965		25B. NAME OF REGISTRAR Robert E. Feltner	25C. FUNERAL DIRECTOR ADDRESS Harpers Ferry, W. Va.



FUNERAL DIRECTOR: IMPORTANT

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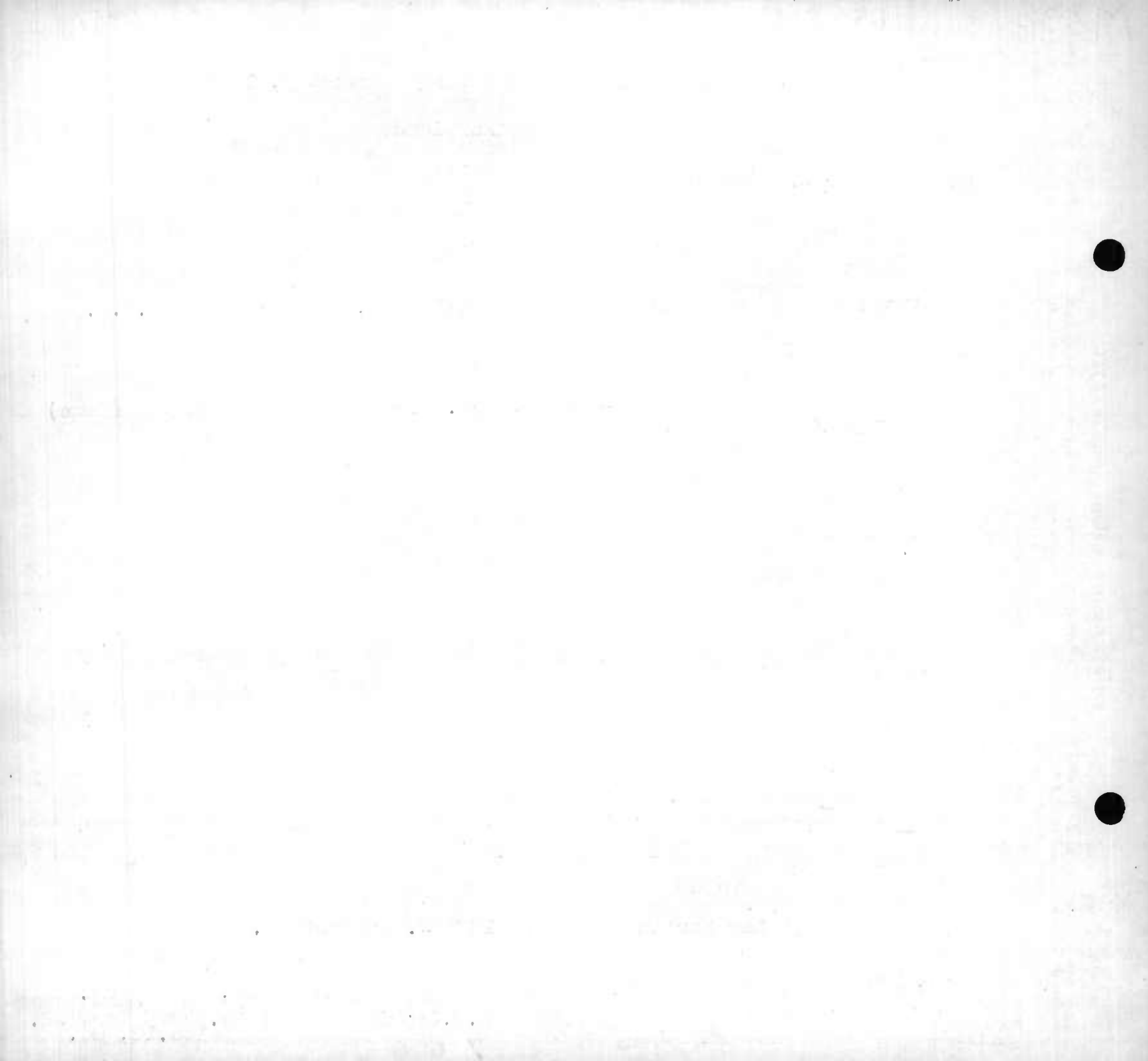
BIRTH NO. <u>65 8146</u>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 8146</u>	
1. NAME OF DECEASED (Type or Print) <u>Carlos E. Rivas</u>				2. DATE AND HOUR OF DEATH <u>Aug 4 1965 11:15 P. M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>36 Church Home and Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>28-04</u>			
5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>				8. DATE OF BIRTH <u>Nov. 4, 1891</u>		9. AGE (In years lost birthday) <u>73</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Cuba</u>	
13. FATHER'S NAME <u>Carlos Rivas</u>				12. CITIZEN OF WHAT COUNTRY? <u>60 yrs USA</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212 07 8444</u>		17. INFORMANT ADDRESS <u>Mrs. Virginia Rivas, 834 Cooks Lane</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Arteriosclerotic Heart Disease</u> DUE TO (B) <u>Coronary Sclerosis</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>16 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>None</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 13 1949</u> to <u>Aug 4 1965</u> that (I) (we) last saw the deceased alive on <u>July 13 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Milton B. Kress</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>Aug 5, 1965</u>			
23C. PHYSICIAN'S NAME (Type) <u>Milton B. Kress, M.D.</u>				23D. ADDRESS <u>Medical Arts Bldg. Balto, Md. 21201</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>Aug. 7/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. 29, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 6 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairley</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Witzke F. H. 4101 Edmondson Ave</u>			

New

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

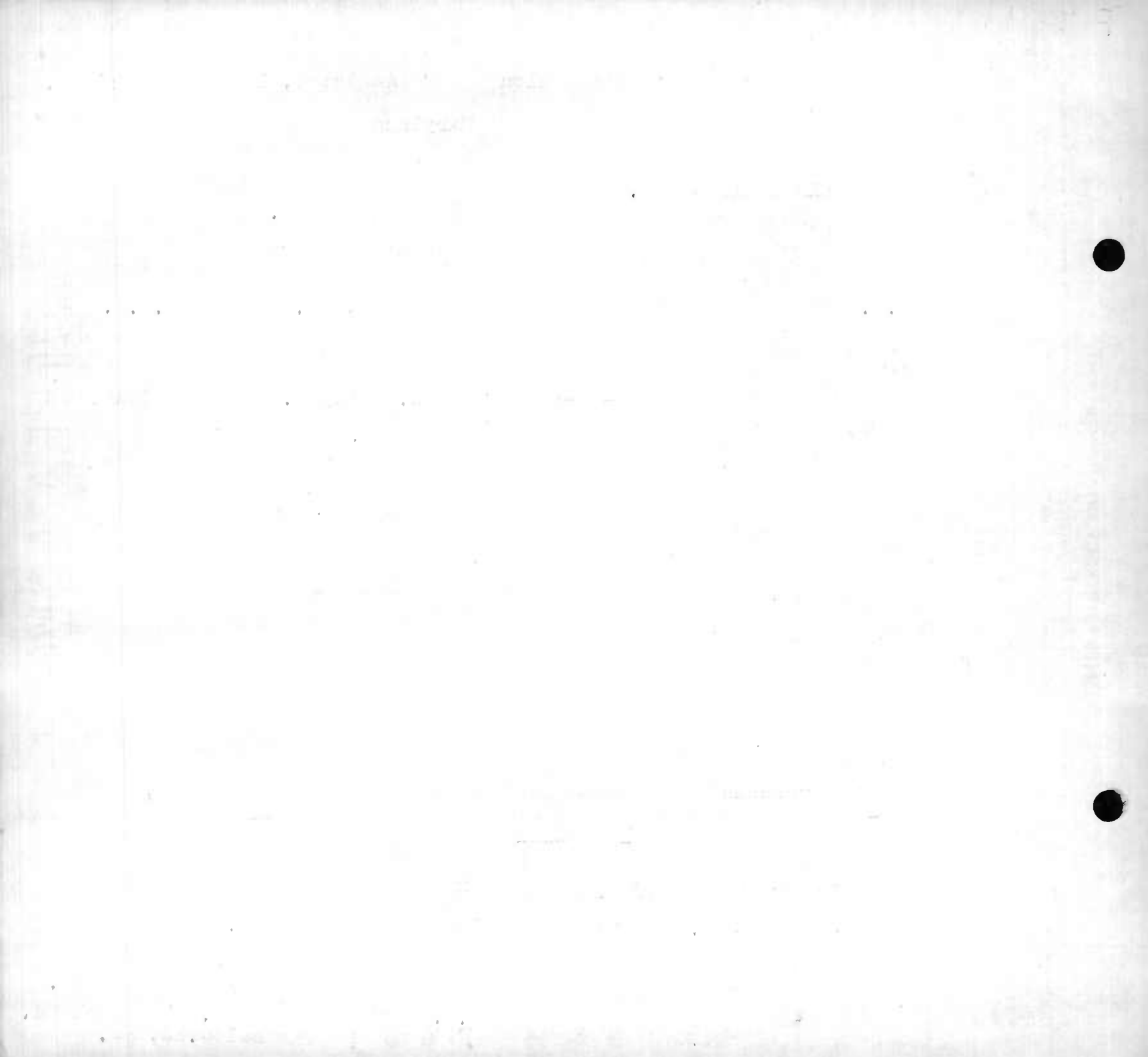
BIRTH NO. 65 8147		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 8147	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Judge Cornelius Patrick Mundy			2. DATE AND HOUR OF DEATH August 5, 1965 9:30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4713 Keswick Road			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-14 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4713 Keswick Road		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	B. DATE OF BIRTH 9/3/1900	9. AGE (in years lost birthday) 64	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10B. KIND OF BUSINESS OR INDUSTRY Law	11. BIRTHPLACE (State or foreign country) Wilmington, Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Patrick Mundy			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-38-1556	17. INFORMANT Mrs. Elizabeth Wright Mundy (Same)		
18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Vascular Occulsion ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. arterio Sclerosis years			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1945 to August 5 1965 , that (I) (we) last saw the deceased alive on August 5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lay Martin			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Aug. 5 1965
23C. PHYSICIAN'S NAME (Type) Lay Martin			23D. ADDRESS 1201 N. Calvert St.		
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 8/5/1965	24C. NAME of CEMETERY or CREMATORY Green Mount		24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

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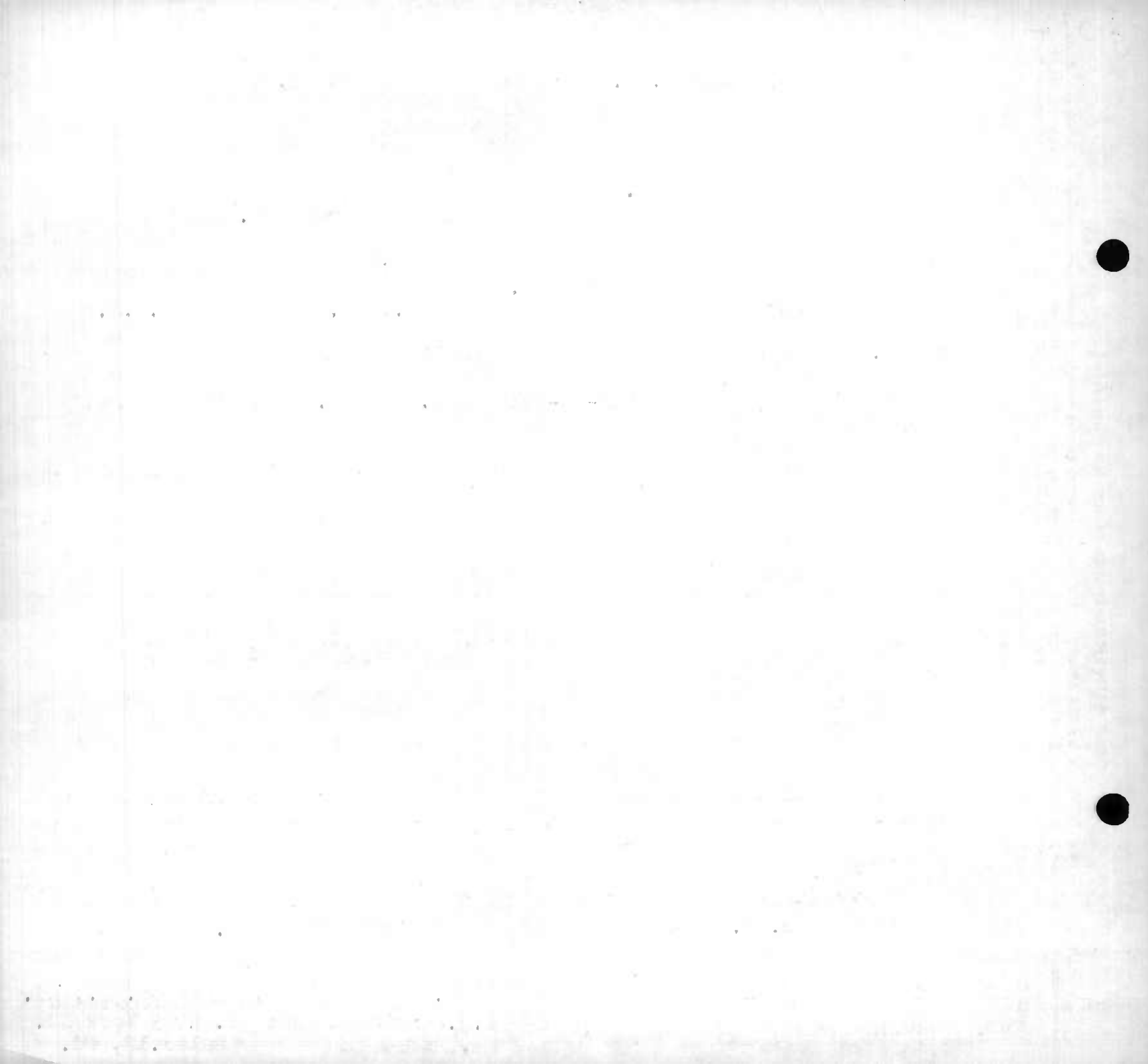
BIRTH NO. 65 8148		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8148	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Michael Francis Fallon			2. DATE AND HOUR OF DEATH August 3, 1965 12:30 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 514 Oakland Ave.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-10 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 514 Oakland Ave.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2/23/1892	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Army		10B. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Michael Fallon			14. MOTHER'S MAIDEN NAME Hettie McGee		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 220-09-6407	17. INFORMANT AB Mrs. Daisy F. Fallon		ADDRESS (Same)
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) INTERVAL BETWEEN ONSET AND DEATH (A) Epidermoid carcinoma of lung (right) 3 yrs. (B) Arteriosclerotic cardiovascular disease 5 yrs. (C)					19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II
19A. DATE OF OPERATION 1/11/63		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of lung		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from February 19 61 to August 3, 19 65, that (I) (we) last saw the deceased alive on August 1, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Lloyd E. Saylor</i>				23B. DATE SIGNED 8/5/1965	
23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor		23D. ADDRESS 3902 Greenmount Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/6/1965	24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1965		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

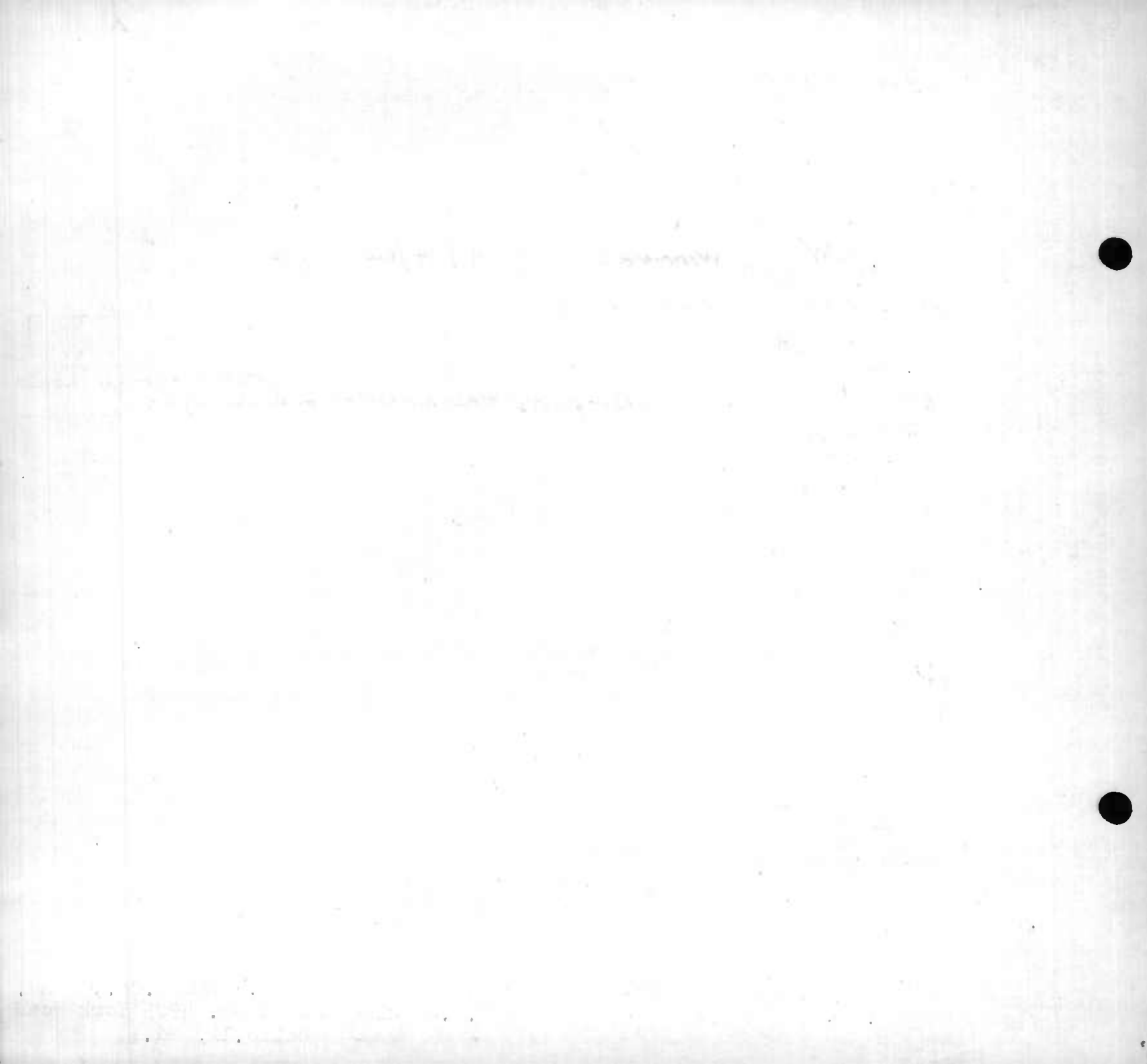
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 8149		CERTIFICATE OF DEATH		Registered No. 65 8149	
1. NAME OF DECEASED (Type or Print) Nicholas W. B. Janetzke				2. DATE AND HOUR OF DEATH August 2, 1965 8.30 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 901 Woodbourne Ave.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-10 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 901 Woodbourne Ave.					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH August 10, 1884		9. AGE (In years last birthday) 80		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent			10B. KIND OF BUSINESS OR INDUSTRY Fidelity Life Co. of America			11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Janetzke				14. MOTHER'S MAIDEN NAME Caroline Herman					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-05-5616		17. INFORMANT Mrs. Mary L. Janetzke		ADDRESS (Same)		
18. 4 21/1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Valvular heart disease aortic stenosis - ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. cause undet.				CAUSE OF DEATH (A) Valvular heart disease aortic stenosis - (B) cause undet. (C)		INTERVAL BETWEEN ONSET AND DEATH years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis, generalized									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (the hospital) attended the deceased from 19 7/6 to 2 August 1965 , that (I) (we) last saw the deceased alive on 2 Aug 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
23A. SIGNATURE M. Theodore Boss M.D.						23B. DATE SIGNED 4 August 1965			
23C. PHYSICIAN'S NAME (Type) Dr. M. Theodore Boss M.D.		23D. ADDRESS Medical Arts Bldg.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/5/1965		24C. NAME of CEMETERY or CREMATORY Lorraine Park Cem.		24D. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co., Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1965		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

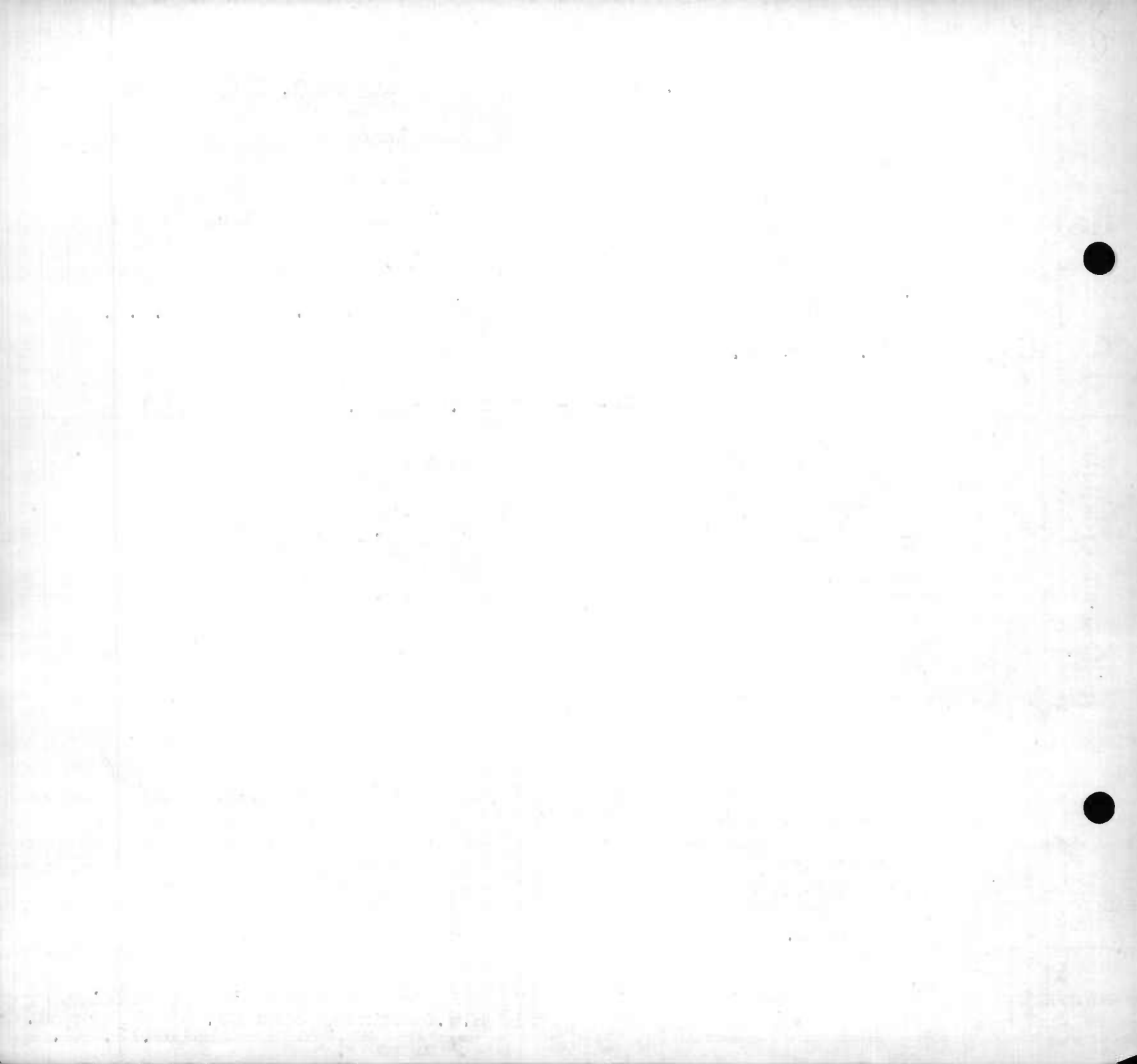
BIRTH NO. 65 8150		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 8150	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) EVA A. GREEN			2. DATE AND HOUR OF DEATH 8/9/65 10:00 a.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 FRANKLIN SQUARE HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 9-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1529 MEDFORD ROAD 18		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 9/14/02	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) BALTIMORE, MD		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME EDWARD H. ULRICH			14. MOTHER'S MAIDEN NAME ANNABELLE HORST		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-05-1176	17. INFORMANT ADDRESS 1529 MEDFORD ROAD MRS. MARGARET A. BUDDEMEYER		
18. 592X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) uremia			CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH 1 month		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. chronic glomerulonephritis			18. DUE TO 4 months		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/3/65 to 8/4/65 , that (I) (we) last saw the deceased alive on 8/4/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Munner				23B. DATE SIGNED 8/4/65	
23C. PHYSICIAN'S NAME (Type) Silvino B. Munner				23D. ADDRESS 101 Calhoun St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/1965		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park	
24D. LOCATION (City, town, or county) (State) Parkville, Balto. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 6 1965			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						BIRTH NO. 65 8151		CERTIFICATE OF DEATH		Registered No. 65 8151	
1. NAME OF DECEASED (Type or Print)						2. DATE AND HOUR OF DEATH					
Winters R. Jones						August 3, 1965 10:15 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)						A. STATE B. COUNTY					
3407 University Place						Maryland 12-02					
						C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
						Baltimore					
						D. STREET ADDRESS (If rural, give location)					
						3407 University Place					
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Yr. Months Days	
M		W		Married		April 17, 1894		71			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Optometrist				Eyes				Baltimore, Md.		U.S.A.	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Hugh H. Jones, Sr.						Mary Blanch					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes WWI						AB 214-14-8105		Mrs. Julia C. Jones (Same)			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH						CAUSE OF DEATH					
(This does not mean the mode of dying, e.g., heart failure, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(A) DUE TO					
						Coronary Occlusion					
						(B) DUE TO					
						Rheumatoid Arthritis					
						(C)					
						Arterio sclerosis					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		(Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from July 30 th 1965 to Aug 3 rd 1965, that (I) (we) last saw the deceased alive on Aug 3 rd 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED			
M. Paul Byerly								8/4/65			
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS					
M. Paul Byerly						5820 York Road					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
Burial		8/5/1965		New Cathedral Cemetery		Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
AUG 6 1965		R. B. E. Jenkins		H.W. Jenkins & Sons Co.		4905 York Rd. Balto. 12, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8152		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8152	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Cornelia A. Gibbs			2. DATE AND HOUR OF DEATH 8/4/65 4:20 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1209 St. Paul St.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 11-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1209 St. Paul St.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 2/22/1877	9. AGE (In years last birthday) 88	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) New York, N. Y.	
13. FATHER'S NAME Frederick Andrews			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-8198		17. INFORMANT Dr. Frederick Gibbs, 1427 Astor St., Chicago 10, Ill.	
18. 433.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Anterior-sclerosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis Sudden death - asystole			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) Electrolyte imbalance		INTERVAL BETWEEN ONSET AND DEATH 4 years 4 months
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED No		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) Feb 29 1965		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 29 1965 to Aug 4 1965 , that (I) (we) last saw the deceased alive on July 30 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Henry M. Thomas Jr.			23B. DATE SIGNED Aug 4, 1965		
23C. PHYSICIAN'S NAME (Type) Henry M. Thomas			23D. ADDRESS 1201 N. Calvert St.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/6/1965		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem.	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 6 1965			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			

Quasi similis - munda
etiam et
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etiam et
—

etiam et
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BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

65 8153

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 8153

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILBUR BESS

2. DATE AND HOUR PRONOUNCED DEAD

7/29/65 8:20 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

CERTIFICATE AMENDED

Mercy Hospital

8/30/65

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

46 Market Place

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
lost birthday)

43

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) ~~Fatty Liver~~ Bronchopneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Fatty Liver

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/30/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY, CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 6 1965

Robert E. Fairley, M.D.

MORTUARY SERVICE - BCHD

Letter from Office of the Chief Medical Examiner. 8/30/65 C. Bowens

BIRTH NO.

65 8154

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 8154

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CLAUDE TYSON

2. DATE AND HOUR PRONOUNCED DEAD

July 29, 1965

3:15 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

300 N. Parrish St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

75

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-29-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

City, town, or county

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 6 1965

Robert E. Fairley M.D.

Irving P. Carroll

MORTUARY SERVICE - BCHD

WALLACE FORBES

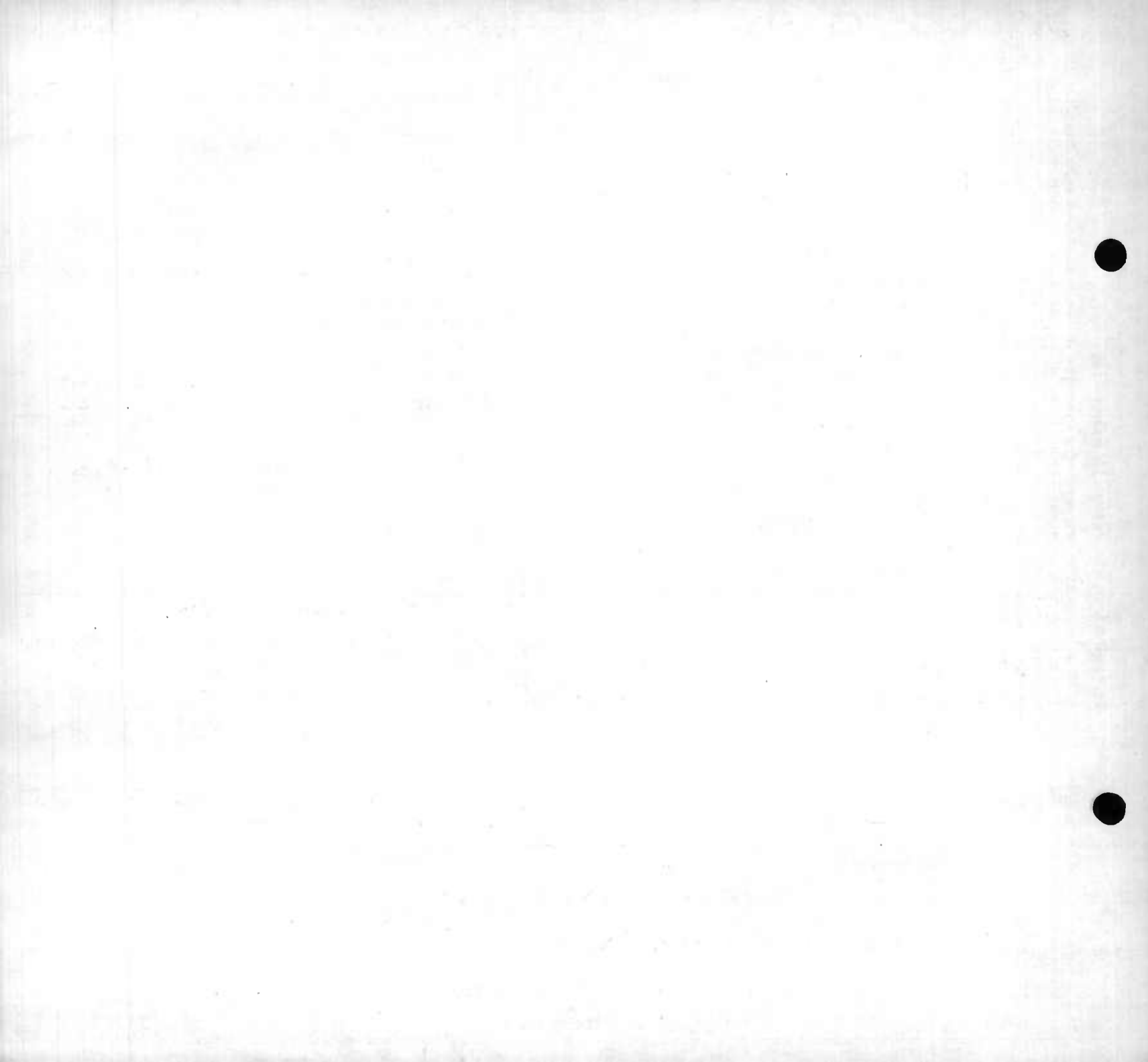
AND ASSOCIATES

George F. Connelley

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

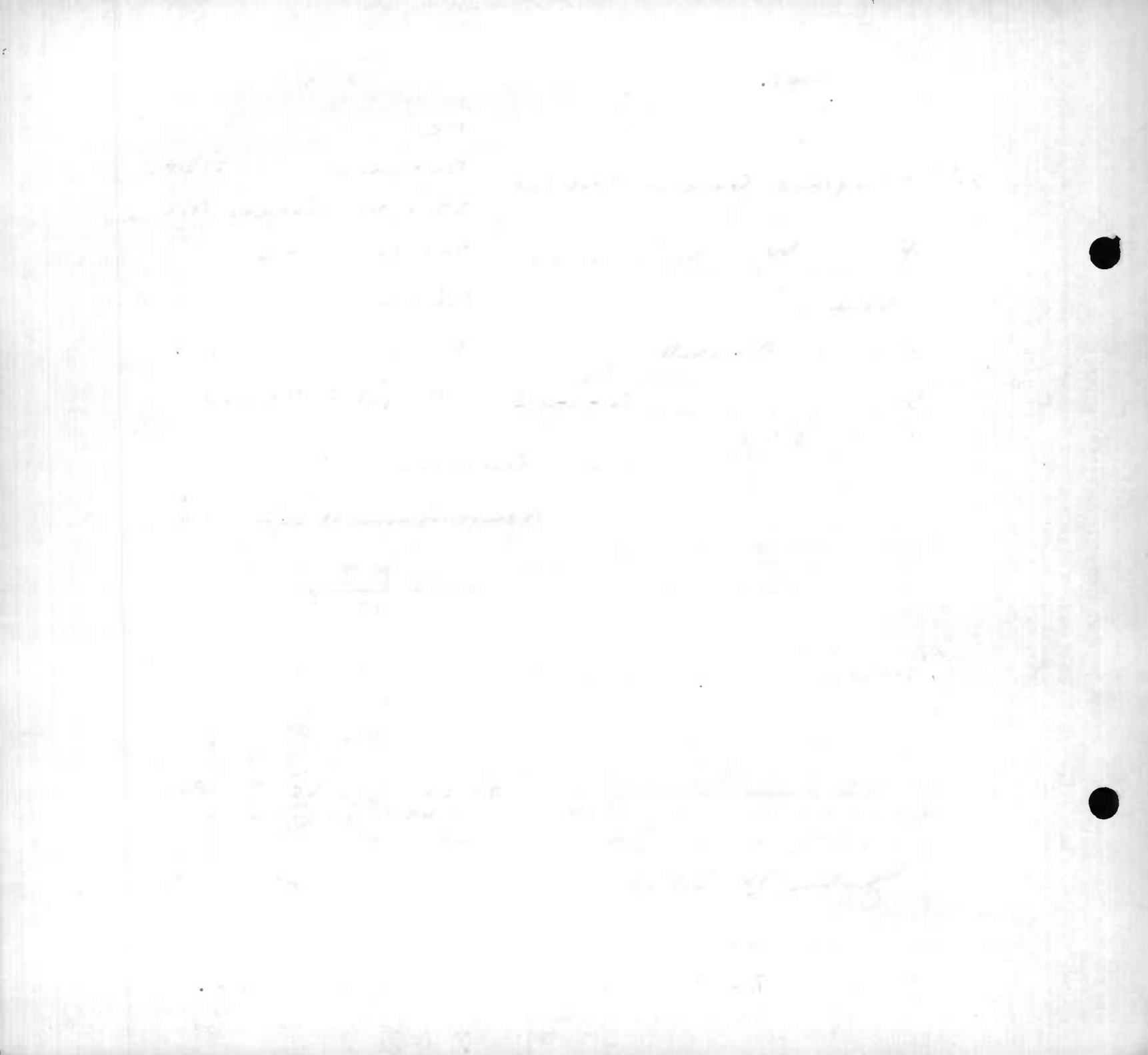
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8155	
BIRTH NO. 65 8155		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Helen Donovan		2. DATE AND HOUR OF DEATH August 2, 1965 9:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3120 St. Paul Street Baltimore, Maryland 21218		A. STATE Maryland B. COUNTY 12-02			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3120 St. Paul Street 21218			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH March 29, 1889	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John A. DeLashmutt			14. MOTHER'S MAIDEN NAME Fannie Simmons		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO.	17. INFORMANT Miss Mary DeLashmutt ADDRESS 3120 St. Paul Street Baltimore, Md. 21218		
18. 42001		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) A-5 heart disease			2 yr.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pan Bin son's disease due to Cerebral arterio-sclerosis 5 yr.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 5, 1955 to Aug 2, 1965 , that (I) was last saw the deceased alive on July 13, 1965 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.					
23A. SIGNATURE H.R. Freeman Jr.		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) H.R. Freeman Jr.		23D. ADDRESS 11 W. 24th St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation	24B. DATE 8/5/1965	24C. NAME OF CEMETERY or CREMATORY Loudon Park Crematory		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE RECEIVED BY HEALTH DEPT. AUG 6 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Wm. J. Cipman & Sons ADDRESS Baltimore, Md. 21217 North Pa. Ave.	



FUNERAL DIRECTOR: IMPORTANT

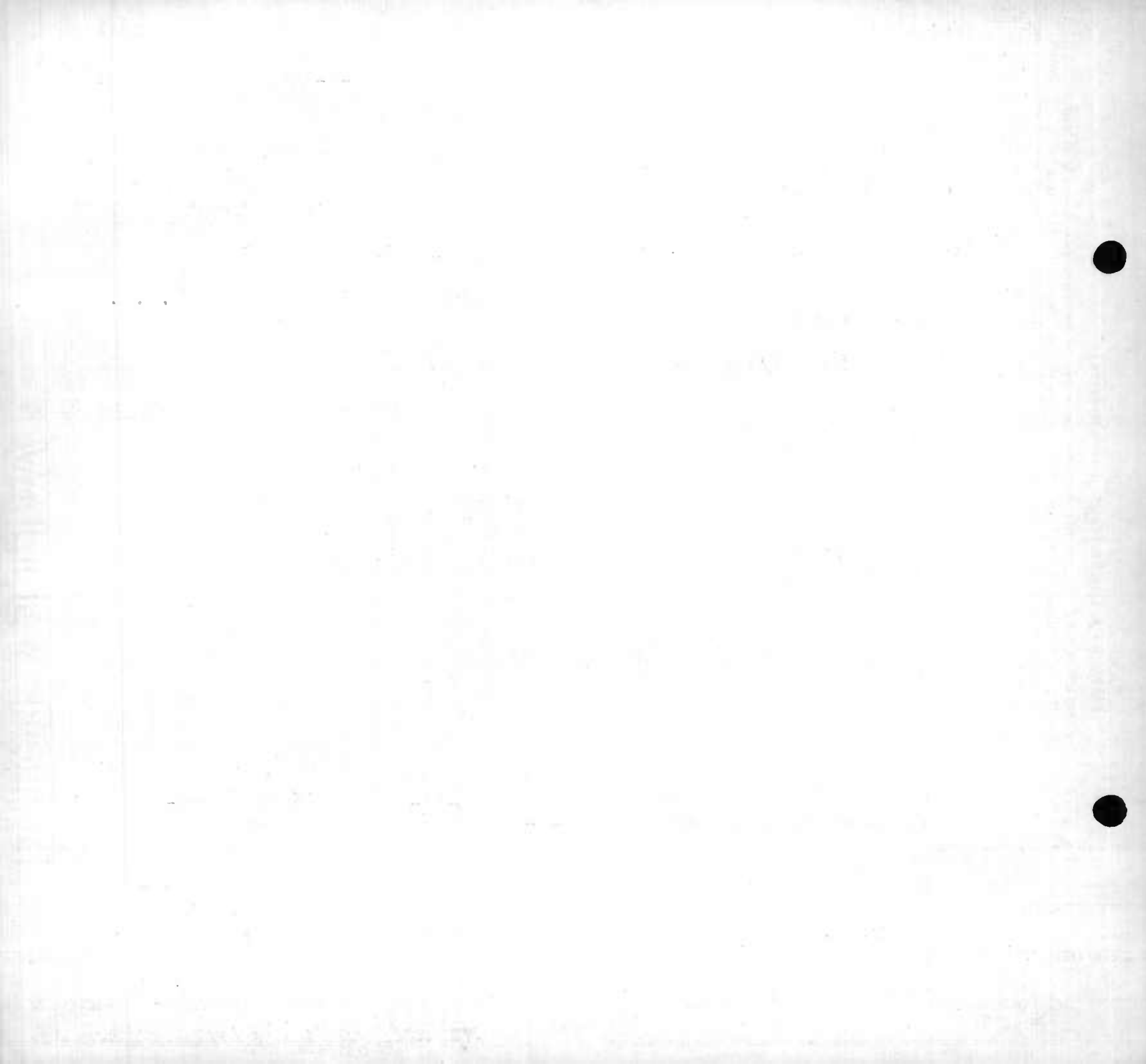
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8156	
BIRTH NO. 65 8156				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) L. Marie Marshall			2. DATE AND HOUR OF DEATH 8-4-65 1 ^{6⁰⁵} P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Maryland General Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 27-15		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21209		
			D. STREET ADDRESS (If rural, give location) 2211 W. Rogers Ave.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 9-4-88	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John E. Marshall			14. MOTHER'S MAIDEN NAME Ellen M. Server		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-16-1841		17. INFORMANT ADDRESS Hospital Record	
18. 153.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Carcinomatosis DUE TO (B) Adenocarcinoma of Sigmoid Colon DUE TO (C) _____		
INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 7-29-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Adenocarcinoma - Sigmoid		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-20 19 65 to 8-4 19 65 , that (I) (we) last saw the deceased alive on 8-4 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John M. Stoffy M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 8-4-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/1965		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION (City, town, or county) (State) Pikesville, Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Wm. F. Fisher & Sons Baltimore, Md. 21217 North Ave., Wt.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K5325 8157		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8157	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				Ruth Knotts	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		2. DATE AND HOUR OF DEATH	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		8-2-1965 8:45 P.M.	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		B. COUNTY 8-04		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location)		2322 East Oliver Street 21213	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1-26-1914	9. AGE (In years lost birthday) 51	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY OWN home		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Fred Sturdivant		14. MOTHER'S MAIDEN NAME Lucy Streeter	
15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-22-1538		17. INFORMATION ADDRESS Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cardiac Arrest DUE TO Arteriosclerotic Cerebral Vascular Disease + Renal Failure (B) Diabetes Mellitus DUE TO (C) Failure		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-25-19 65 to 8-2-19 65, that (I) (we) lost saw the deceased alive on 8-2-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. Rathbun		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-2-1965	
23C. PHYSICIAN'S NAME (Type) Dr. H. Rathbun		23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 8-6-65		24C. NAME of CEMETERY or CREMATORY Sturdivant Cemetery Wadesboro, N.C.	
24D. LOCATION (City, town, or county) (State) Wadesboro, N.C.		25A. DATE REC'D BY HEALTH DEPT. AUG 6 1965		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Randolph J. Collick		25D. ADDRESS 1412 E. Preston St.			



BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED
(Type or Print)

CLEMON JONES

2. DATE AND HOUR PRONOUNCED DEAD

August 4, 1965

7:20 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

2221 E. Chase St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

9-24-1906

9. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Crainfellow

10B. KIND OF BUSINESS OR INDUSTRY

Steel Co.

11. BIRTHPLACE (State or foreign country)

Cumberland, Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas Jones

14. MOTHER'S MAIDEN NAME

Ruth Hatcher

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W. 2

16. SOCIAL
SECURITY NO.

216-11-5121

17. INFORMANT

Pinkie Lee Jones 2221 E. Chase St.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenacker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9-4-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

8-6-65

23C. NAME OF CEMETERY or CREMATORY

Hatcher Cemetery

23D. LOCATION

(City, town, or county)

Cumberland, Va.

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 6 1965

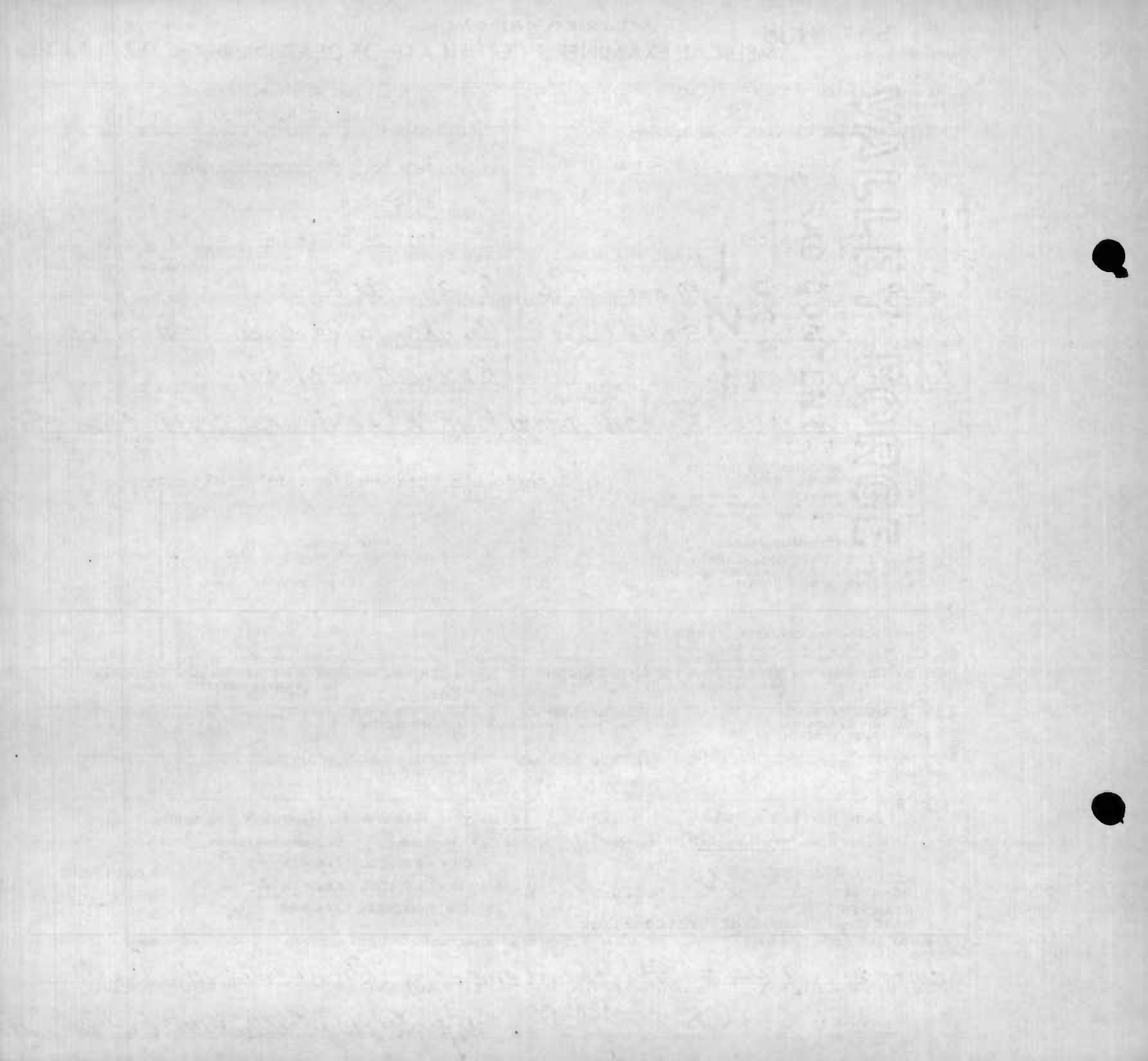
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Randolph J. Collick 1412 E. Preston St.

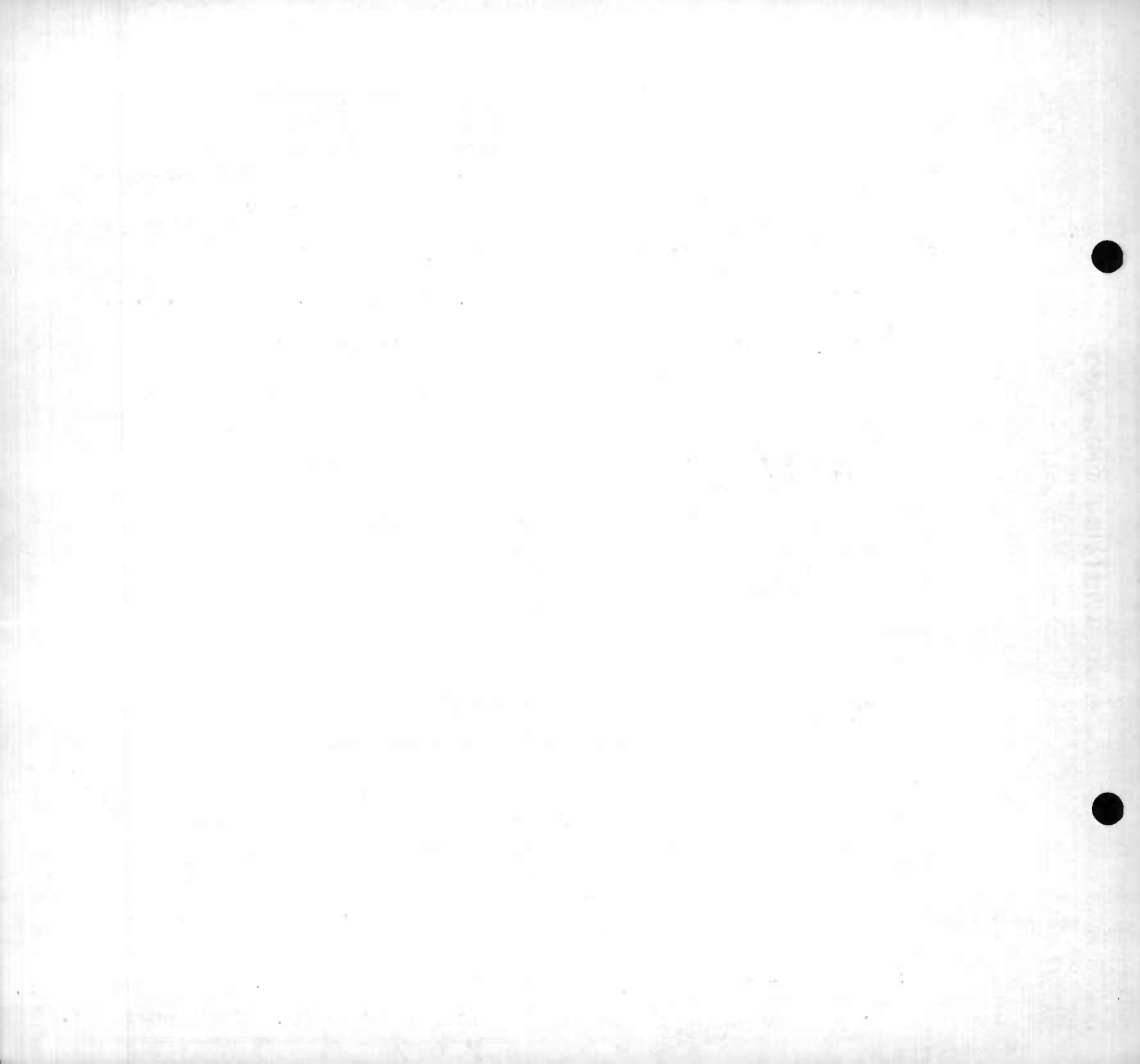
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 8159		CERTIFICATE OF DEATH		65 8159	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ALBAN, Stanley		2. DATE AND HOUR OF DEATH 8-5-65 11 05 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Church Home and Hospital		A. STATE MD B. COUNTY Balto			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto			
		D. STREET ADDRESS (If rural, give location) 117 S. Broadway			
5. SEX Male	6. RACE White	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH May 3, 1898	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician,		10B. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) Mt. Carmel, Penna.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Bolick Albanowicz		14. MOTHER'S MAIDEN NAME Valeria Krauczewicz	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Joseph McCormick 117 S. Broadway	
18. 332X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Cerebrovascular accident			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO due to mid cerebral artery thrombosis, left, massive			
		(C) MIAD.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 31 19 65 to Aug 8 19 65 , that (I) (we) last saw the deceased alive on Aug 5 65 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Nathan		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8.5.65	
23C. PHYSICIAN'S NAME (Type) A. NATHAN		23D. ADDRESS Church Home and Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-9-1965		24C. NAME of CEMETERY or CREMATORY Mother of Consolation	
24D. LOCATION (City, town, or county) (State) Mount Carmel, Northumberland, Pa.		25A. DATE REC'D BY HEALTH DEPT. AUG 6 1965			
25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901 Eastern Ave.			



1
8100

65 8160

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 8160

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HILDA B. JUBB

2. DATE AND HOUR PRONOUNCED DEAD

August 4, 1965 7:08 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1755 Homestead Street

5. SEX

Female

6. RACE

Caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Mar. 22, 1899

9. AGE (In years
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Carl F. Heuer

14. MOTHER'S MAIDEN NAME

Frederika Knospe

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218 46 2867

17. INFORMANT

ADDRESS

Raymond D. Jubb - 1755 Homestead St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/5/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/7/65

23C. NAME of CEMETERY or CREMATORY

Moreland Memorial Park

23D. LOCATION

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 6

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

Robert C. Altenburg
6111 Marlora Rd.

ADDRESS

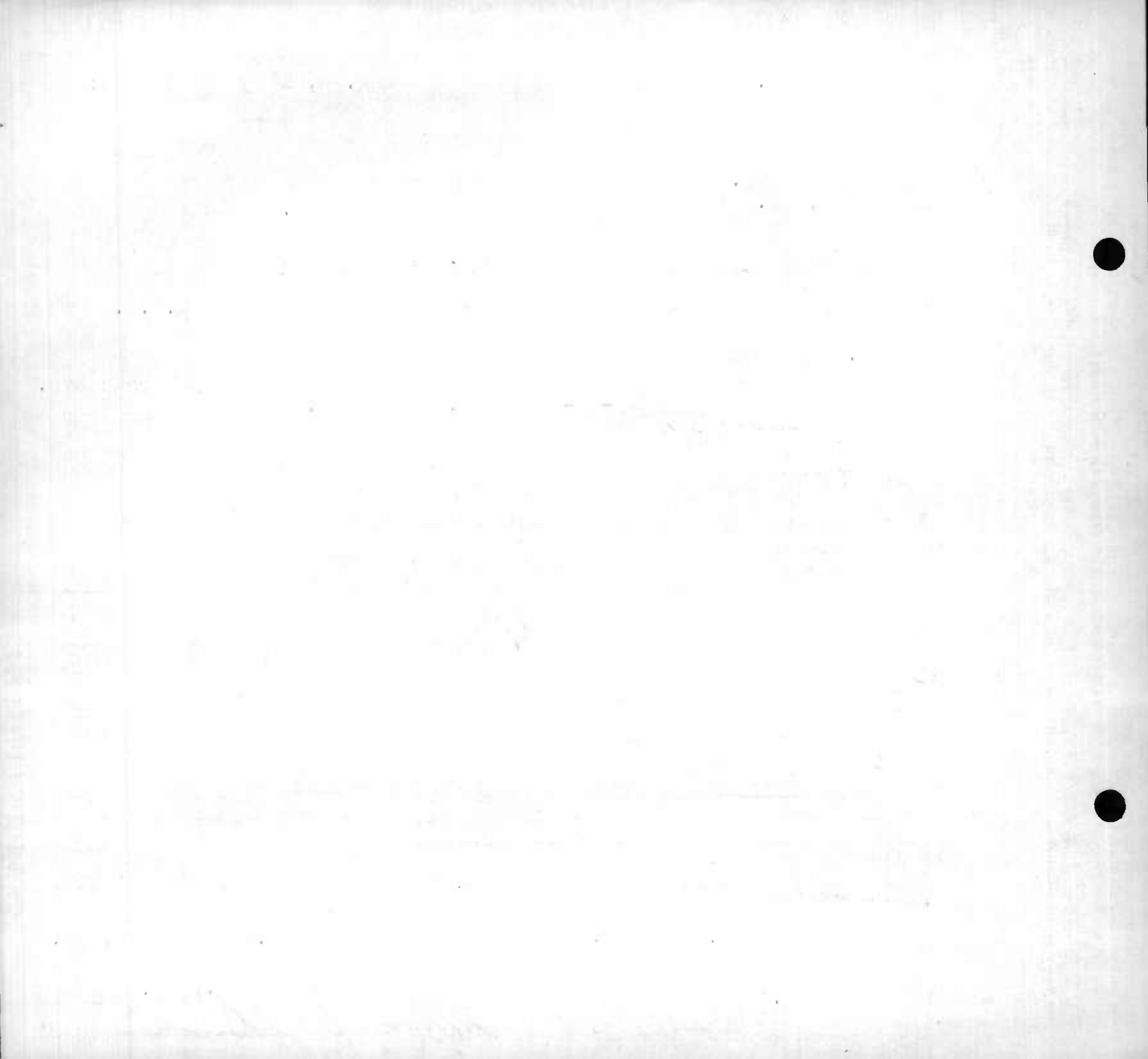
WALLLEY & CO

WALLLEY & CO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8161	
BIRTH NO. 65 8161		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Walter E. Brickman		2. DATE AND HOUR OF DEATH Aug. 4, 1965 7:00A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 5419 Purdue Ave. Baltimore, Md. 21212		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-38			
		D. STREET ADDRESS (If rural, give location) 5419 Purdue Ave. 21212			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Aug. 4, 1898	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10B. KIND OF BUSINESS OR INDUSTRY Home Improvement		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Harry T. Brickman		14. MOTHER'S MAIDEN NAME Grace Turfield			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-03-0057		17. INFORMANT Mrs. Georgia B. Brickman ADDRESS 5419 Purdue Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 163X-1-260X		CAUSE OF DEATH (A) DUE TO Carcinoma of Lung (Small cell type) (B) DUE TO Cerebral + gent metastases (C) DUE TO Arteriosclerosis Heart Disease Ch failure		INTERVAL BETWEEN ONSET AND DEATH 6 Mos	
19. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Mar 8 1963 to Aug 4 1965 , that (I) (we) last saw the deceased alive on Aug 3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald W. Mintzer M.D.				23B. DATE SIGNED Aug 5 1965	
23C. PHYSICIAN'S NAME (Type) Donald W. Mintzer, M.D.				23D. ADDRESS 3009 Evergreen Ave., Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/65		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith	
24D. LOCATION Baltimore Co., Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 6 1965			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR William J. [Signature]		25D. ADDRESS 8521 Loch Raven B'	

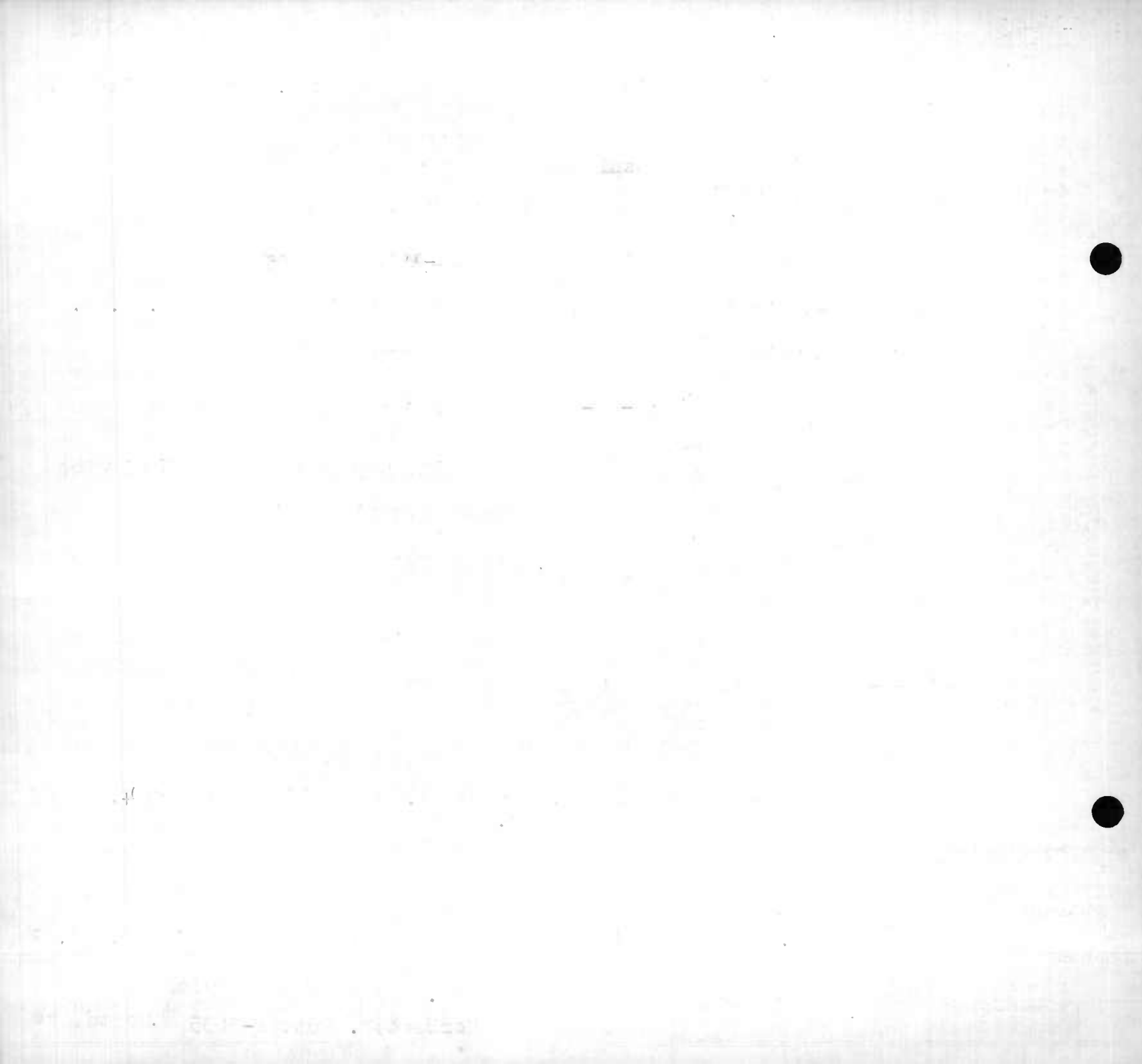


VS: 36-44-231

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

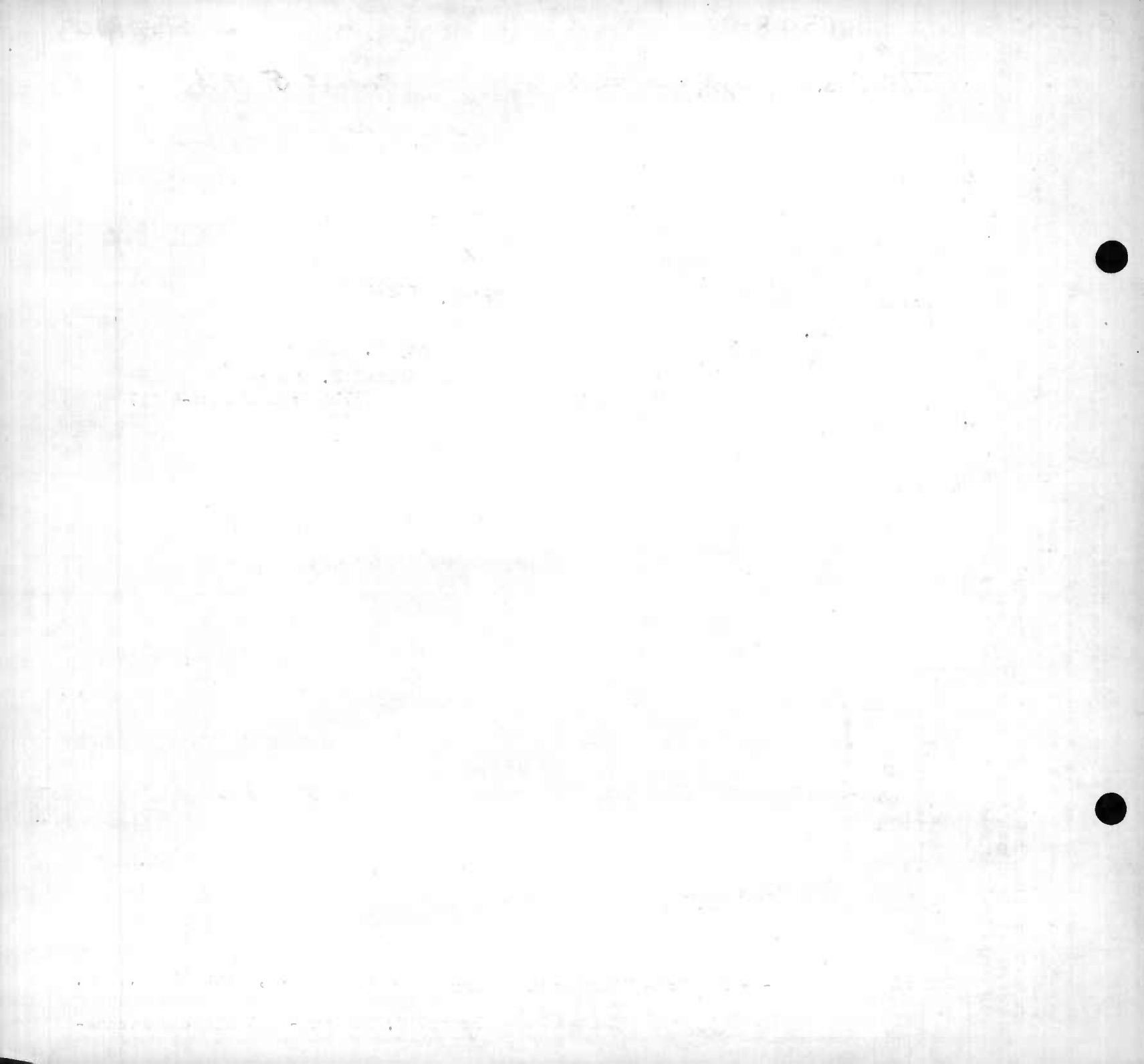
BIRTH NO. 65 8162		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8162	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
John Lewis		August 4, 1965		3:00 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		Maryland 16-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
D. STREET ADDRESS (If rural, give location)		3035 Arunah Avenue #21216			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours Min.
Male	Negro	Married	6-9-1900	65	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer-Retired		Construction		North Carolina	
12. CITIZEN OF WHAT COUNTRY?		U. S. A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Andrew Lewis		Mary ? ? ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		216-07-8902		RECORDS: BCH: 4940 Eastern Avenue #24	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) Acute Pulmonary Embolus			
ANTECEDENT CAUSES		DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Thrombophlebitis			
		(B) DUE TO			
		(C) Varicose Veins			
II		Severe Cardiomegaly			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
8-3-65		Suspected Ruptured Aneurysm		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
				Yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from August 3, 19 65 to August 4, 19 65, that (I) (we) last saw the deceased alive on August 4, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Dr. Donald Baltzan				August 4, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Donald Baltzan		M.D. 4940 Eastern Avenue Baltimore, Md. #24			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8/7/65		Carver Memorial Pk.	
				Laurel Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 6 1965		Herbert E. Nutter		3035 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH						Registered No. <u>65-8163</u>
BIRTH NO. <u>65 8163</u>		1. NAME OF DECEASED (Type in full) <u>THOMAS E. GARRYA (also Gary)</u>				2. DATE AND HOUR OF DEATH <u>August 5, 1965</u> <u>12</u> <u>PM</u>
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Lutheran Hospital of Maryland</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1722 Hall Ave.</u>				
5. SEX <u>M</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never married</u>	8. DATE OF BIRTH <u>1/3/47</u>	9. AGE (In years last birthday) <u>18 yrs</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto. Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel E. Thomas</u>			14. MOTHER'S MAIDEN NAME <u>Mary C. Weedon</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Samuel E. Thomas</u> ADDRESS <u>1722 Hall Avenue-21227</u>		
18. <u>744.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Respiratory failure</u> DUE TO (B) <u>Weakness of Respiratory muscles</u> DUE TO (C) <u>Progressive Musc. Atrophy</u>		INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>Feb 7-26</u> <u>1965</u> to <u>8-4</u> <u>1965</u> , that (I) (we) last saw the deceased alive on <u>Aug. 4</u> <u>1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE <u>Inia C. Espina</u>				23B. DATE SIGNED <u>8-5-65</u>		
23C. PHYSICIAN'S NAME (Type) <u>INIA C. ESPINA</u>		23D. ADDRESS M.D. <u>Lutheran Hospital of Maryland</u> <u>730 Ashburton St.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-7-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lake View Memorial Park</u>		
24D. LOCATION <u>Sykesville, Carroll Co., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 6 1965</u>				
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>				
25D. ADDRESS <u>4107 Wilkens Avenue-21229</u>						



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 665 88164 X				BALTIMORE CITY HEALTH DEPT. CERTIFICATE OF DEATH		Registered No. 65 8164	
1. NAME OF DECEASED (Type or Print) WILLIAM P. BERGMAN				2. DATE AND HOUR OF DEATH AUGUST 5, 1965 5:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALDWIN 53-00 D. STREET ADDRESS (If rural, give location) GREEN ROAD			
5. SEX M	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9-18-87	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10B. KIND OF BUSINESS OR INDUSTRY GEN. FARMING		11. BIRTHPLACE (State or foreign country) CHICAGO, ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GUSTAV BERGMAN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-32-7902		17. INFORMANT Boyd 330 ADDRESS Road ANNA BERGMAN (WIFE) Baldwin, Md.			
18. 332 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Thrombotic occlusion of the right middle cerebral artery ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. arteriosclerotic vascular disease and idiopathic hypertension				CAUSE OF DEATH (A) Thrombotic occlusion of the right middle cerebral artery (B) arteriosclerotic vascular disease (C) and idiopathic hypertension			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JULY 19 19 65 to AUGUST 5 19 65 , that (I) (we) last saw the deceased alive on AUGUST 5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Samuel C. Gresham 23C. PHYSICIAN'S NAME (Type) SAMUEL C. GRESHAM				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED AUGUST 5, 1965	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 8/7/1965			
24C. NAME OF CEMETERY or CREMATORY Bel Air Memorial Gardens				24D. LOCATION (City, town, or county) (State) Bel Air Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Charles E. Kuntz ADDRESS Jannettsville Md			

WEDNESDAY 12 FEBRUARY

ARRIVED 7.15 PM

WENT TO HOSPITAL

ORANGE ROAD

IN CHAIRMAN MARKED

7.15-8.15

RETURNED

11.15 AM

CARBY BROWN

UNKNOWN

FROM BROWN (A.M.)

the whole of the right
side of the chest
and upper abdomen

NO

James C. Brown

1 FEBRUARY 1951

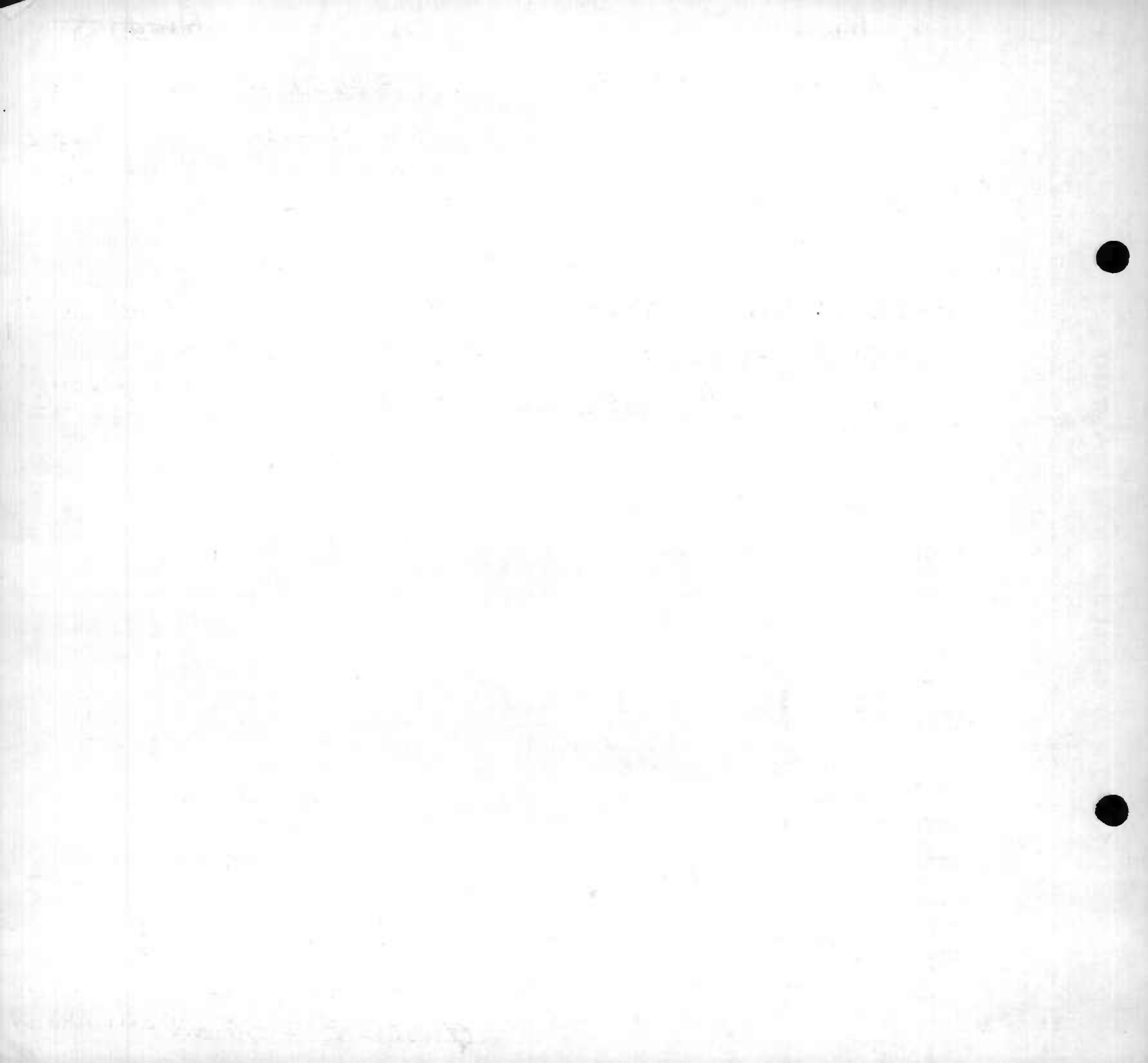
RECEIVED 12 FEBRUARY 1951

12 FEBRUARY 1951

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>65 8165</u>	
BIRTH NO. <u>665 88165</u>							
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <u>RICHARD G. ANDERS</u>		2. DATE AND HOUR OF DEATH <u>AUGUST 4, 1965 8:15 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		6. CITY OR TOWN (If outside city limits, write RURAL and give township)		7. STATE	
<u>3719 BEECH AVE</u>				<u>MARYLAND</u>		<u>13-07</u>	
15. SEX <u>M</u>		16. RACE <u>W</u>		17. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>		18. DATE OF BIRTH <u>AUG 13, 1902 62</u>	
19. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BANK RUNNER</u>		20. KIND OF BUSINESS OR INDUSTRY <u>BANK</u>		21. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		22. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
23. FATHER'S NAME <u>JESSE ANDERS</u>				24. MOTHER'S MAIDEN NAME <u>MINNIE CREAMER</u>			
25. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NONE</u>				26. SOCIAL SECURITY NO. <u>215-22-5595</u>		27. INFORMANT <u>MRS HELEN M. ANDERS</u>	
28. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Deconpunction</u>				29. CAUSE OF DEATH (A) <u>Myocardial Deconpunction</u>		30. INTERVAL BETWEEN ONSET AND DEATH <u>Several weeks</u>	
31. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Emphysema</u>				(B) <u>Emphysema</u>		<u>Indefinite</u>	
32. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Asstuma</u>				(C) <u>Asstuma</u>		<u>Indefinite</u>	
33. MEDICAL CERTIFICATION				34. MEDICAL CERTIFICATION			
35. DATE OF OPERATION <u>May 26</u>		36. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Aug 3</u>		37. AUTOPSY? (Yes or No) <u>Yes</u>		38. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
39. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		40. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		41. WHERE DID INJURY OCCUR? <u>Home</u>		(If in Baltimore City, give exact location)	
42. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPRDX.) <u>May 26 1961</u>		43. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		44. HOW DID INJURY OCCUR? <u>Aug 3 1965</u>			
45. I certify that (I) (this hospital) attended the deceased from <u>May 26 1961</u> to <u>Aug 3 1965</u> and that (I) (we) lost saw the deceased alive on <u>Aug 3 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
46. SIGNATURE <u>Nathaniel M Beck</u>				47. M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		48. DATE SIGNED <u>Aug 4-65</u>	
49. PHYSICIAN'S NAME (Type) <u>NATHANIEL M. BECK</u>				50. ADDRESS <u>2818 ST PAUL ST.</u>			
51. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		52. DATE <u>AUG 7/65</u>		53. NAME of CEMETERY or CREMATORY <u>DRUID RIDGE CEM.</u>		54. LOCATION (City, town, or county) (State) <u>BALTIMORE CO. MD.</u>	
55. DATE REC'D BY HEALTH DEPT. <u>AUG 6 1965</u>		56. NAME OF REGISTRAR <u>Robert E. Taylor</u>		57. FUNERAL DIRECTOR <u>Austin E. Donovan</u>		58. ADDRESS <u>3818 Roland Ave</u>	



1
B630

65 88166		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 88166	
M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
JESSE BROADWAY, Jr.		August 1, 1965 3:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland B. COUNTY 15-09	
University Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 3016 Chelsea Terrace			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 3/1/38
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY contractor	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jesse Broadway, Sr.		14. MOTHER'S MAIDEN NAME Blanche Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219-32-8238	
17. INFORMANT Mazola Broadway		ADDRESS 3016 Chelsea Terrace	
18. CAUSE OF DEATH E 816.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple Traumatic Injuries. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
21C. WHERE DID INJURY OCCUR? Dorsey and Ridge Roads, A.A.Co.		21D. TIME OF INJURY (APPROX.) 8 1 '65 A	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Auto-Auto collision.	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 8/7/65	
23C. NAME OF CEMETERY or CREMATORY Mt. Calvary cem.		23D. LOCATION (City, town, or county) (State) Brooklyn, D.C. Md.	
24A. DATE REC'D BY HEALTH DEPT. AUG 6 1965		24B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
24C. FUNERAL DIRECTOR W. L. Chetman, Jr.		ADDRESS 1701 McCulloch St. Balt. Md.	

WALL BY FORCE

10/1/32
N.C.

For [illegible] in [illegible]
[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]

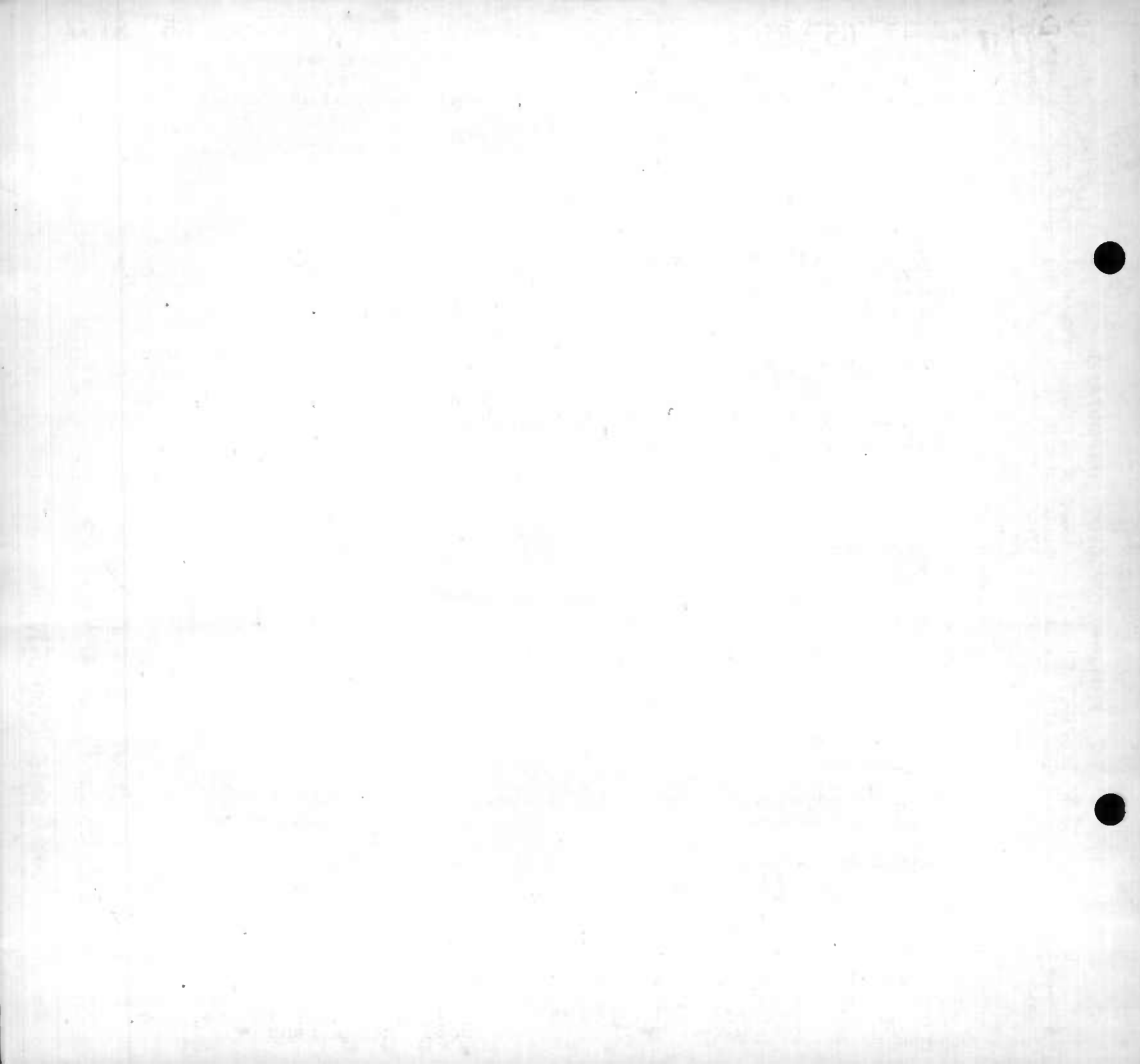
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[illegible] [illegible] [illegible]
[illegible] [illegible] [illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

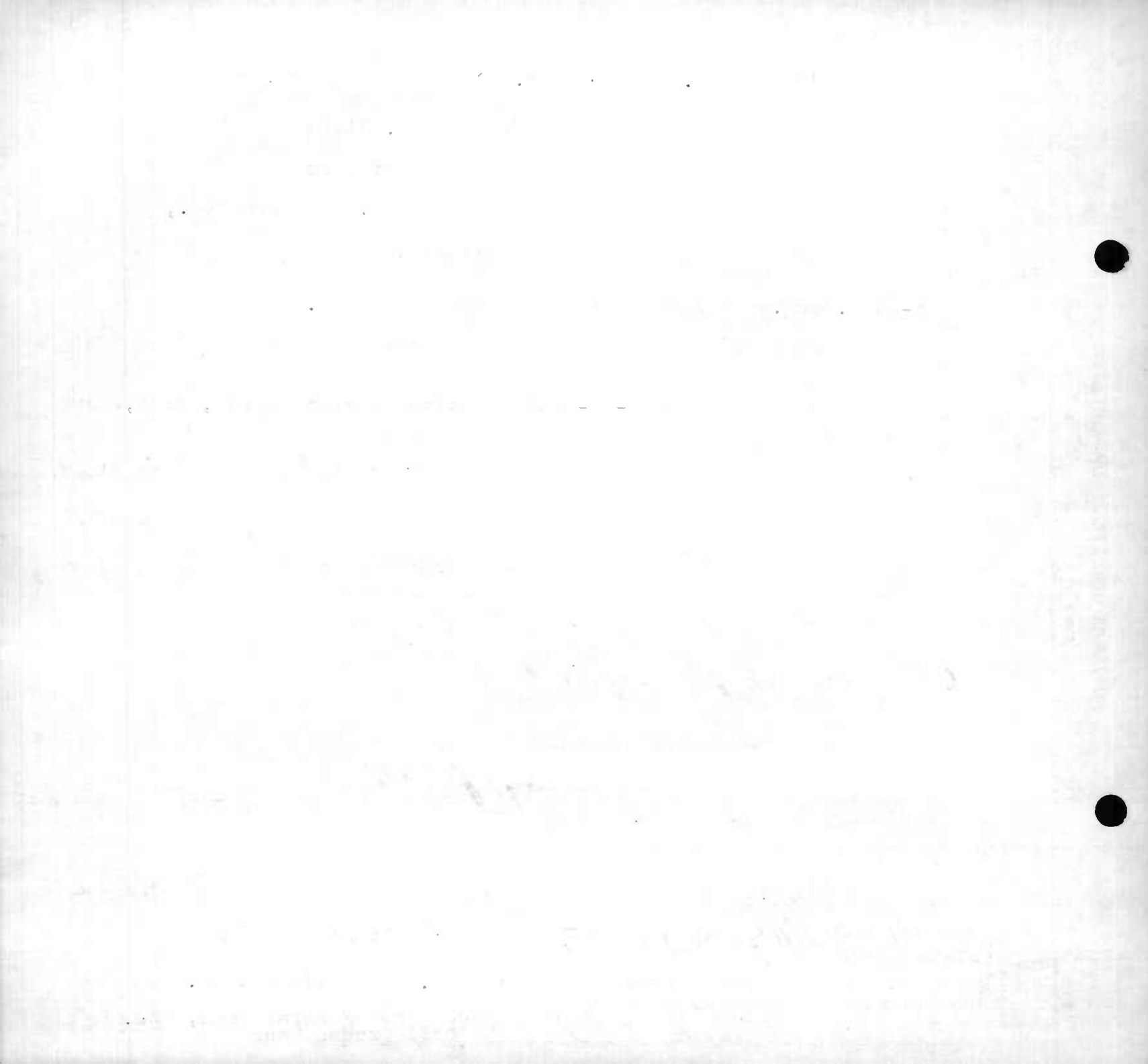
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 8167		CERTIFICATE OF DEATH		Registered No. 65 8167	
1. NAME OF DECEASED (Type or Print) DESHNER, CARRIE E.				2. DATE AND HOUR OF DEATH Aug 7, 1965 2:40 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore					
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 20					
				D. STREET ADDRESS (If rural, give location) Box 323 RFD 16					
5. SEX FEMALE	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8-16-11	9. AGE (In years last birthday) 53	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Lovell				14. MOTHER'S MAIDEN NAME ANNIE BAER or Bayer					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Howard Deshner, husband, above				
18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) CARDIAC FAILURE (Arythmia)				CAUSE OF DEATH (A) CARDIAC FAILURE (Arythmia) DUE TO				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) END STAGE Breast Cancer DUE TO				Approx. 11 Years	
(C) Metastatic Breast Cancer								2y	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? INJURY		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Aug 7th @ 2:30 PM 19 65 to Aug 7th @ 2:40 PM 19 65 , that (I) (we) last saw the deceased alive on Aug 7th 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE R. Darryl Fisher MD				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> House Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Aug. 9, 1965			
23C. PHYSICIAN'S NAME (Type) R. DARRYL FISHER				23D. ADDRESS JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/65		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1965		25B. NAME OF REGISTRAR Robert E. Taylor MD		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.			ADDRESS 3331 Brehms Lane		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C 600 65 8168		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8168	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED	
65 8168				CHARLES L. CORRIE Sr.	
2. DATE AND HOUR OF DEATH		8-5-65		1:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Md. 21224		B. COUNTY	
Mercy Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
D. STREET ADDRESS (If rural, give location)		29 N. Highland Ave.,			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
MALE	WHITE	MARRIED	9/12/1900	64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Ret-Auto.Mech.		Kress Dairy		Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
		John Corrie		Clara Hopkins	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		213-03-4245		Nellie Donahue Corrie, wife, above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		4 months	
ANTECEDENT CAUSES		(B) DUE TO		2 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO		7 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		anti choleliths			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
7/19/62		CA of esophagus		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		7/1/65	
22. I certify that (I) (this hospital) attended the deceased from		19 65 to 8-5		19 65	
that (I) (we) lost saw the deceased alive on		8/5/65		and that in (my) (our) opinion death occurred on the date	
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
S. S. Moravato				8/5/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
SHARON H. S. MORAVATO		Mercy Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8/9/65		Gardens of Faith Cem.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
Baltimore, Md.		AUG 6 1965		Schimunek Funeral Home, Inc.	
25C. FUNERAL DIRECTOR ADDRESS		25D. NAME OF REGISTRAR		25E. NAME OF REGISTRAR	
7331 Prehms Lane		Robert E. Taylor		7331 Prehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8169		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 8169	
1. NAME OF DECEASED (Type or Print) MINA MARIE MORRIS			2. DATE AND HOUR OF DEATH AUGUST 4, 1965 8:45 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE PENNSYLVANIA B. COUNTY WAYNESBORO C. CITY OR TOWN (If outside city limits, write RURAL and give township) WAYNESBORO D. STREET ADDRESS (If rural, give location) 102 MADISON AVE		
5. SEX F	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11-28-06	9. AGE (In years lost birthday) 58	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOSEPH D. MOWEN			14. MOTHER'S MAIDEN NAME ANNIE ALMA BROUARD		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 173-03-1988	17. INFORMANT DECEASED		
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction, posterior wall ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Obstruction of the left coronary artery Pulmonary edema, severe			INTERVAL BETWEEN ONSET AND DEATH 24 hours		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JULY 22 1965 to AUGUST 4 1965 , that (I) (we) last saw the deceased alive on AUGUST 4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Samuel C. Gresham			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED AUGUST 4, 1965
23C. PHYSICIAN'S NAME (Type) Samuel Gresham			23D. ADDRESS M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 8/7/1965	24C. NAME OF CEMETERY OR CREMATORY GREEN HILL CEMETERY		24D. LOCATION (City, town, or county) (State) WAYNESBORO, FRANKLIN CO. PA	
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Walter J. Lane	
				ADDRESS Waynesboro, Pa	

WILLIAM A. HARRIS

FRANKLIN H.

WILLIAM A.

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65 8170

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 8170

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROSE KACZMARCIK

2. DATE AND HOUR PRONOUNCED DEAD

August 3, 1965

4:00 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

South Baltimore General

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3717 Everett St.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

July 28, 1922

9. AGE (In years
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Shoe Store

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Nicholas Bonacci

14. MOTHER'S MAIDEN NAME

Catherine Molinaro

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Paul Kaczmarcik, 3717 Everett St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hemorrhagic shock
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Gunshot wound of neck
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Supermarket

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

14 Hammonds Lane

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8 3 65 ?

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Shot during robbery

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-4-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Aug. 7, 1965

23C. NAME of CEMETERY or CREMATORY

Holy Cross Cemetery

23D. LOCATION

(City, town, or county)

(State)

Ritchie Hgwy., A.A.Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 6 1965

24B. NAME OF REGISTRAR

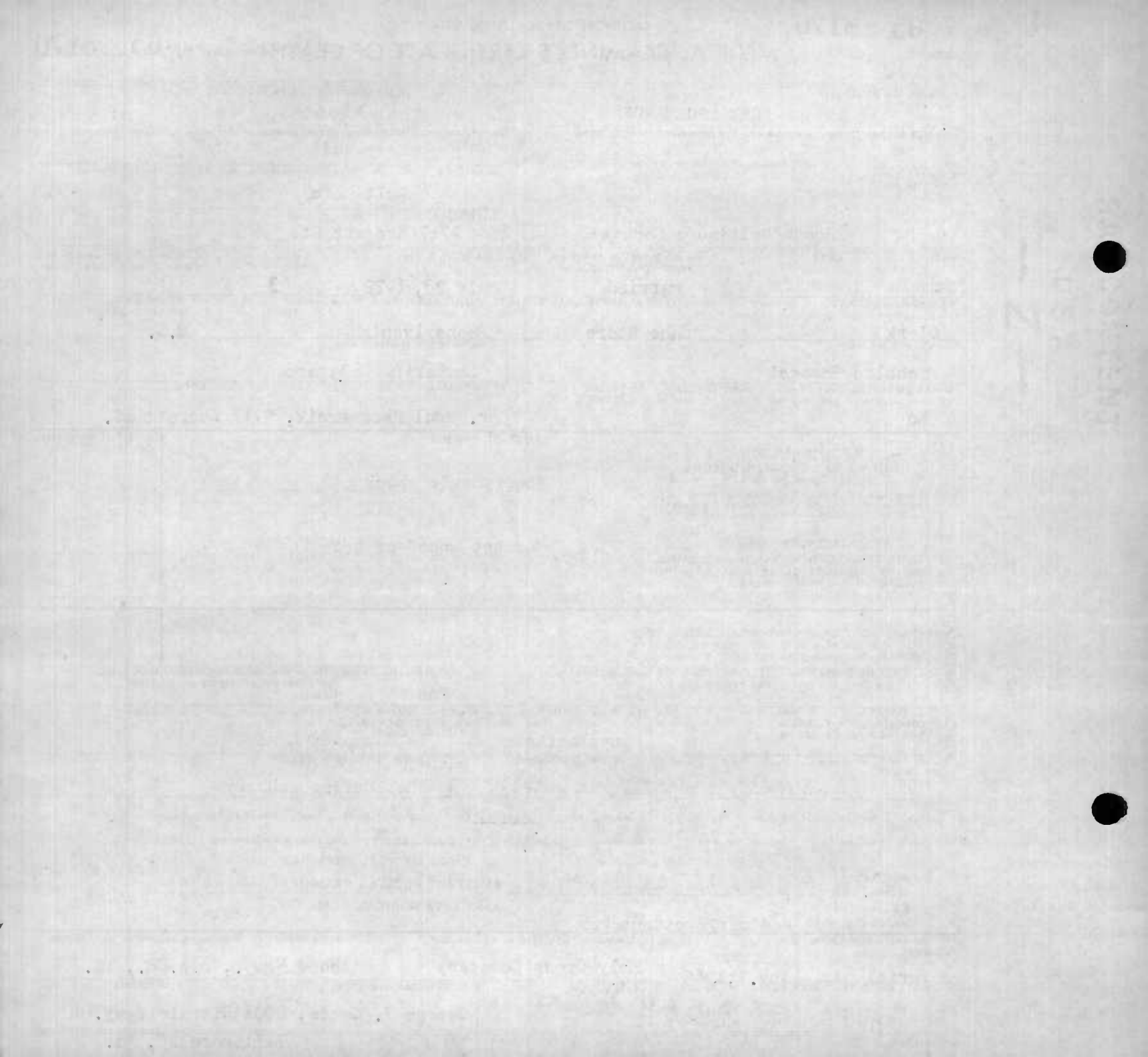
Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

George J. Gonce, 4001 Ritchie Hgwy.

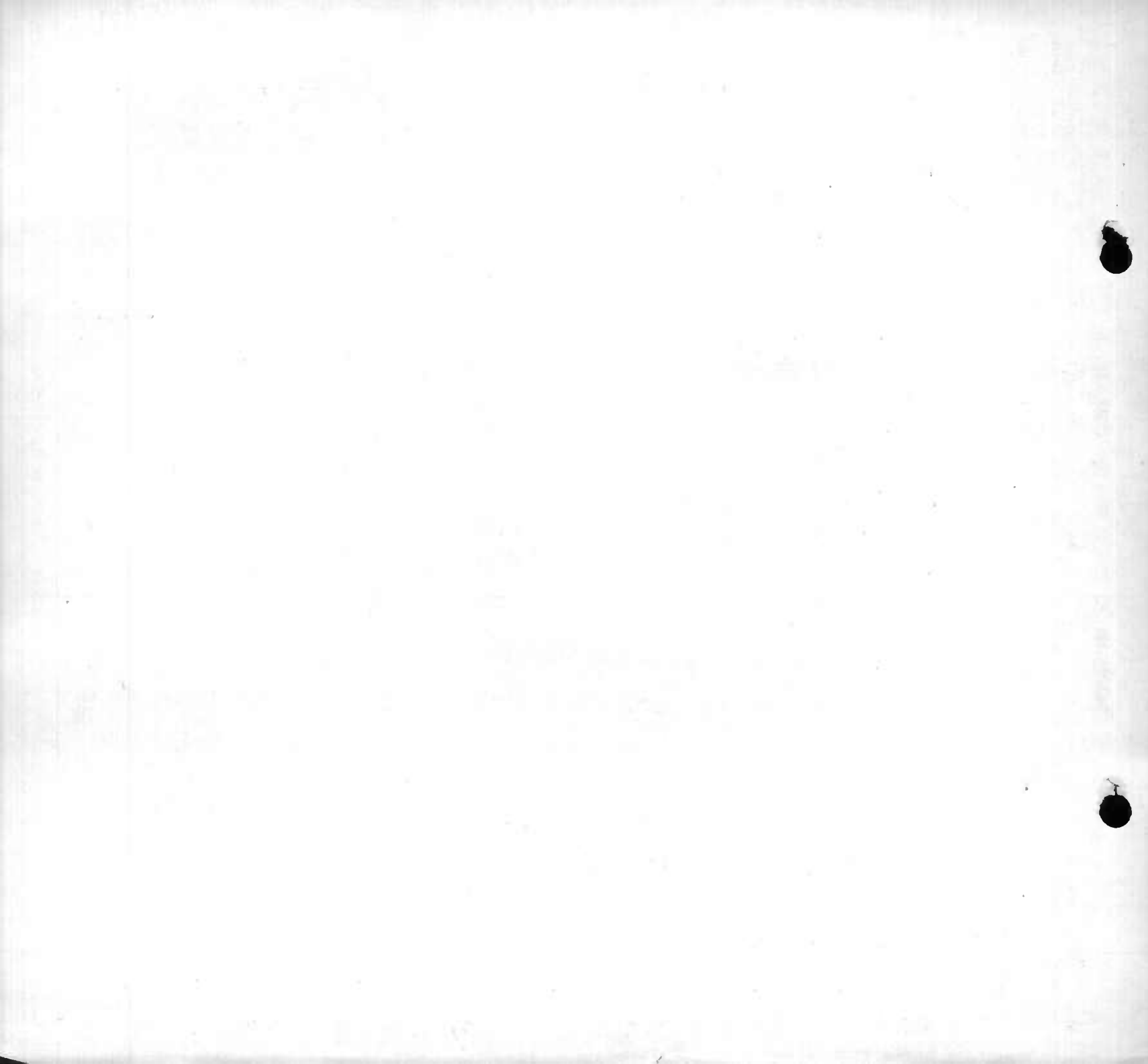
Baltimore 25, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8171	
1. NAME OF DECEASED (Type or Print) <u>Sorrell, Mabel</u>			2. DATE AND HOUR OF DEATH <u>August 5, 1965</u> <u>5:25</u> P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>39 Provident Hospital</u> <u>1514 Division Street</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>19-02</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>216 N. Mount Street</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Separated</u>	8. DATE OF BIRTH <u>4/9/29</u>	9. AGE (In years lost birthday) <u>36</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>LUKE BARNES</u>		
14. MOTHER'S MAIDEN NAME <u>MABEL DAVIS</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <u>MABEL BARNES 111 N. Mount St</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of Breast to Metastasis.</u>			INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>August 4, 1965</u> to <u>August 5, 1965</u> , that (I) (we) lost saw the deceased alive on <u>August 5, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Alvin Thompson</u>			23B. DATE SIGNED <u>8/5/65</u>		
23C. PHYSICIAN'S NAME (Type) <u>Dr. Alvin Thompson</u>			23D. ADDRESS <u>1514 Division Street</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/10/65</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt Auburn</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 9 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fadden</u>		25C. FUNERAL DIRECTOR <u>Marshall P. Hays</u>		25D. ADDRESS <u>638 N. Mount St</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 8172

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HOM

SUEY

2. DATE AND HOUR PRONOUNCED DEAD

August 4, 1965

11:10 P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1818 W. Pratt Street

5. SEX

Male

6. RACE

Chinese

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

About-Jan- 1897

9. AGE (In years
last birthday)

68 (about)

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

retired

10B. KIND OF BUSINESS OR INDUSTRY

Laundry

11. BIRTHPLACE (State or foreign country)

China

12. CITIZEN OF
WHAT COUNTRY?
? (in U.S. 45yrs)

13. FATHER'S NAME

could not ascertain

14. MOTHER'S MAIDEN NAME

could not ascertain

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

no

no

16. SOCIAL
SECURITY NO.

114-07-0715

17. INFORMANT

ADDRESS

Mr. Herman Kim (friend) 913-E-Balto-St-21202

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease or
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/5/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

burial

23B. DATE

Aug-9-65

23C. NAME of CEMETERY or CREMATORY

Lorraine Park

23D. LOCATION

(City, town, or county)

(State)

Woodlawn, Balto-21207

24A. DATE REC'D BY HEALTH DEPT.

AUG 9 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Stewart & Mowen Co. 108-W-North-Av-21201

518

Co

518 Co

Charles J. [illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8173		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8173	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MR. ROBERT E. GILL Sr.		2. DATE AND HOUR OF DEATH 8-5-65 11:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Balto. C. CITY OR TOWN (If outside city limits, write RURAL and give township) RANDELLSTOWN 53-00 D. STREET ADDRESS (If rural, give location) 3600 MILLSTONE RD.			
5. SEX MALE	6. RACE CAUC.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH Aug 9 1899	9. AGE (In years lost birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) BALTO. CO.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME EDWARD GILL			14. MOTHER'S MAIDEN NAME IDA BAUBLITS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-22-7684	17. INFORMANT ROBERT GILL ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) ACUTE RENAL FAILURE DUE TO (B) SEVERE DEHYDRATION DUE TO (C) ACUTE MEMBRANOUS NECROTIZING ENTERO COLITIS SEVERE CHRONIC PYELONEPHRITIS & ASCVD ?		INTERVAL BETWEEN ONSET AND DEATH 5 days 6 days approx	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 8-3 19 65 to 8-5 19 65, that (I) (we) last saw the deceased alive on 8-5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mary Jim Ratner		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 8-5-65		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Aug. 9, 65	24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore Md.		
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965	25B. NAME OF REGISTRAR Robert E. Fink	25C. FUNERAL DIRECTOR ADDRESS J. F. Eline & Sons Reisterstown, Md.			

1. 1st. 1st. 1st.

2. 2nd. 2nd. 2nd.

3. 3rd. 3rd. 3rd.

4. 4th. 4th. 4th.

5. 5th. 5th. 5th.

6. 6th. 6th. 6th.

7. 7th. 7th. 7th.

8. 8th. 8th. 8th.

9. 9th. 9th. 9th.

10. 10th. 10th. 10th.

11. 11th. 11th. 11th.

12. 12th. 12th. 12th.

13. 13th. 13th. 13th.

14. 14th. 14th. 14th.

15. 15th. 15th. 15th.

16. 16th. 16th. 16th.

17. 17th. 17th. 17th.

18. 18th. 18th. 18th.

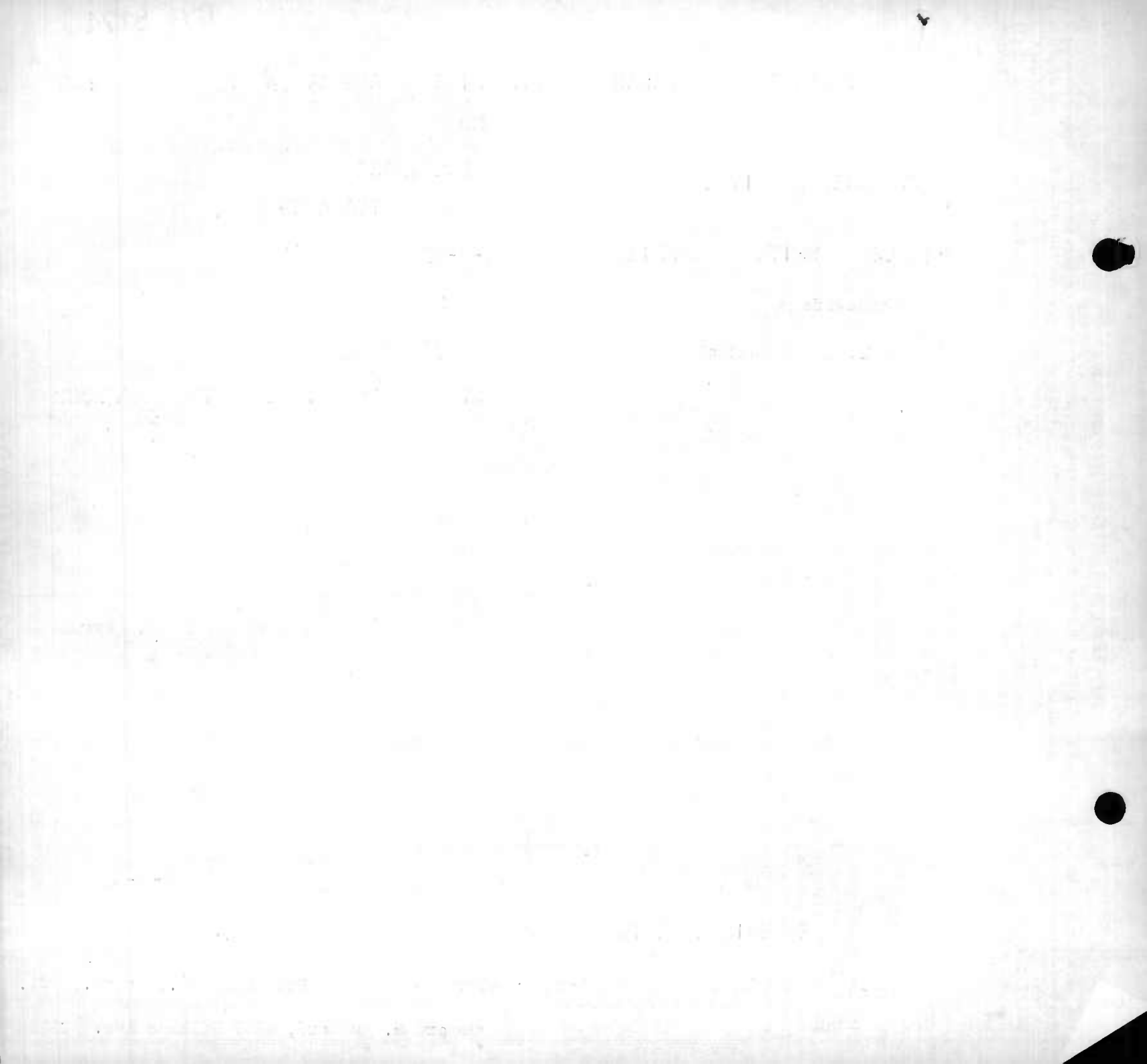
19. 19th. 19th. 19th.

20. 20th. 20th. 20th.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

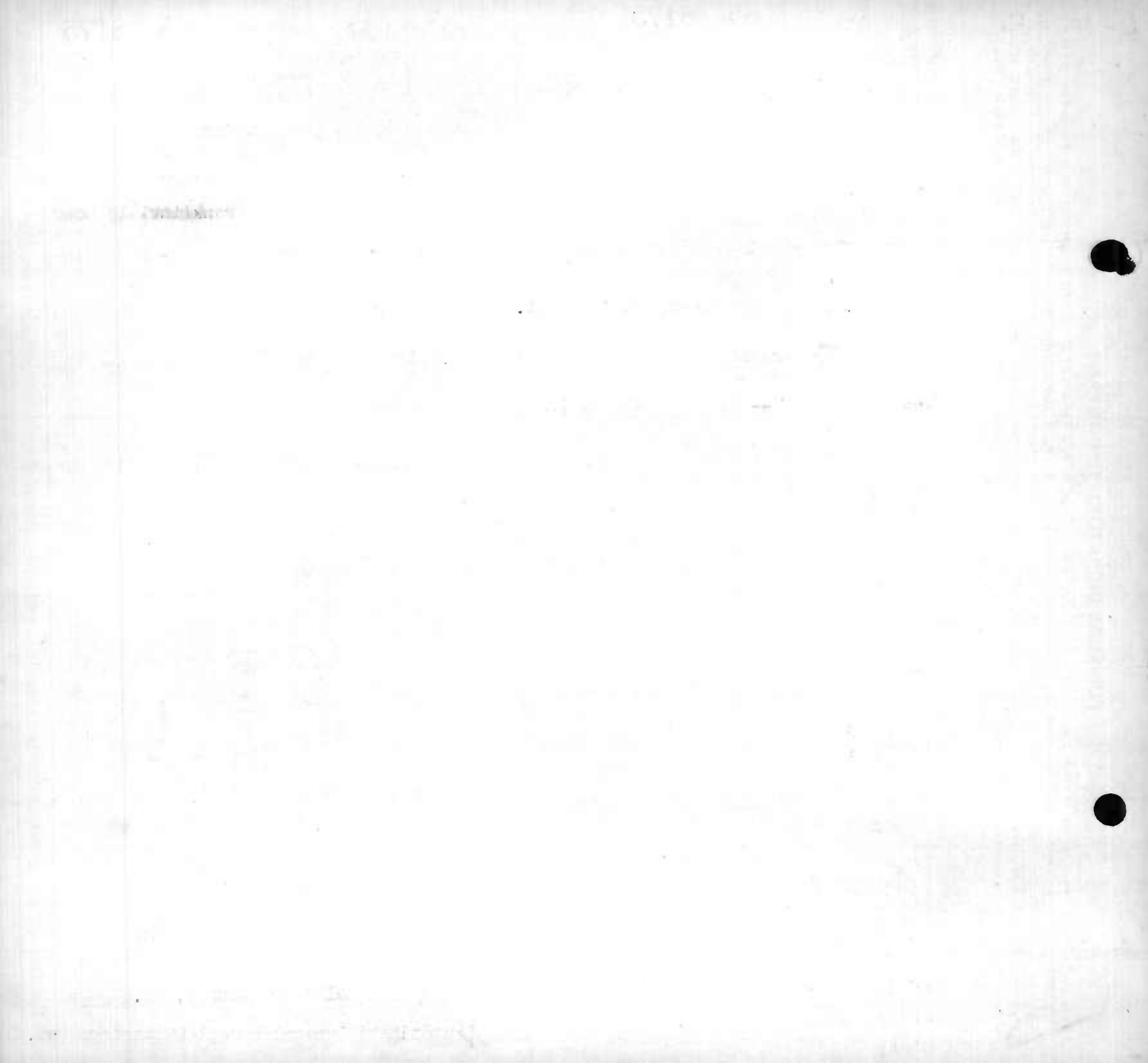
BIRTH NO. 65 8174				BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 65 8174	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
BURGESS SARAH CATHERINE				AUGUST 4 1965		3:00P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL				A. STATE MD B. COUNTY			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
				D. STREET ADDRESS (If rural, give location)			
				805 UNETTA AVENUE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
FEMALE	WHITE	MARRIED		4-6-03	62		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				MD			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JULIUS Nunenthal				MARY MADDOX			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
						ST AGNES HOSPITAL CATON & WILKENS AVENUE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES				INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) myocardial infarction acute 3 hrs (B) ASCVD (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				metastatic carcinoma of breast primary adenocarcinoma of the rectum			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 7/16 1965 to 8/4 1965, that (I) (we) last saw the deceased alive on 8/4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Eugenio E Benitez				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-4-65	
23C. PHYSICIAN'S NAME (Type) EUGENIO E BENITEZ				23D. ADDRESS 3350 Wilkens Avenue 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/7/1965		Loudon Park Cemetery		3801 Frederick Rd., Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 9 1965		Robert E. Taylor		Howard H. Hubbard		4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8175				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8175	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CRUSSE, HENRY CARL				2. DATE AND HOUR OF DEATH August 3 1965 9:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY Harford	
				C. CITY OR TOWN Joppa		(If outside city limits, write RURAL and give township) 62-00	
				D. STREET ADDRESS (If rural, give location) Rt 1 Box 72 Franklinville Road Rd.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12/24/24		9. AGE (In years last birthday) 40	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10B. KIND OF BUSINESS OR INDUSTRY County Police Dept.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Crusse				14. MOTHER'S MAIDEN NAME Elizabeth Zulauf			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 212 20 7160		17. INFORMANT Medical Records		ADDRESS	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 10 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO arteriosclerotic heart disease		years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C)			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 24 1965 to August 3 1965 , that (I) (we) last saw the deceased alive on August 3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Barry N. Rosenbaum				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/3/65	
23C. PHYSICIAN'S NAME (Type) BARRY N. ROSENBAUM				23D. ADDRESS UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/65		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore County, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Farkowski		25C. FUNERAL DIRECTOR Frank J. Farkowski Funeral Home 1407 Eastern Ave. 21			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

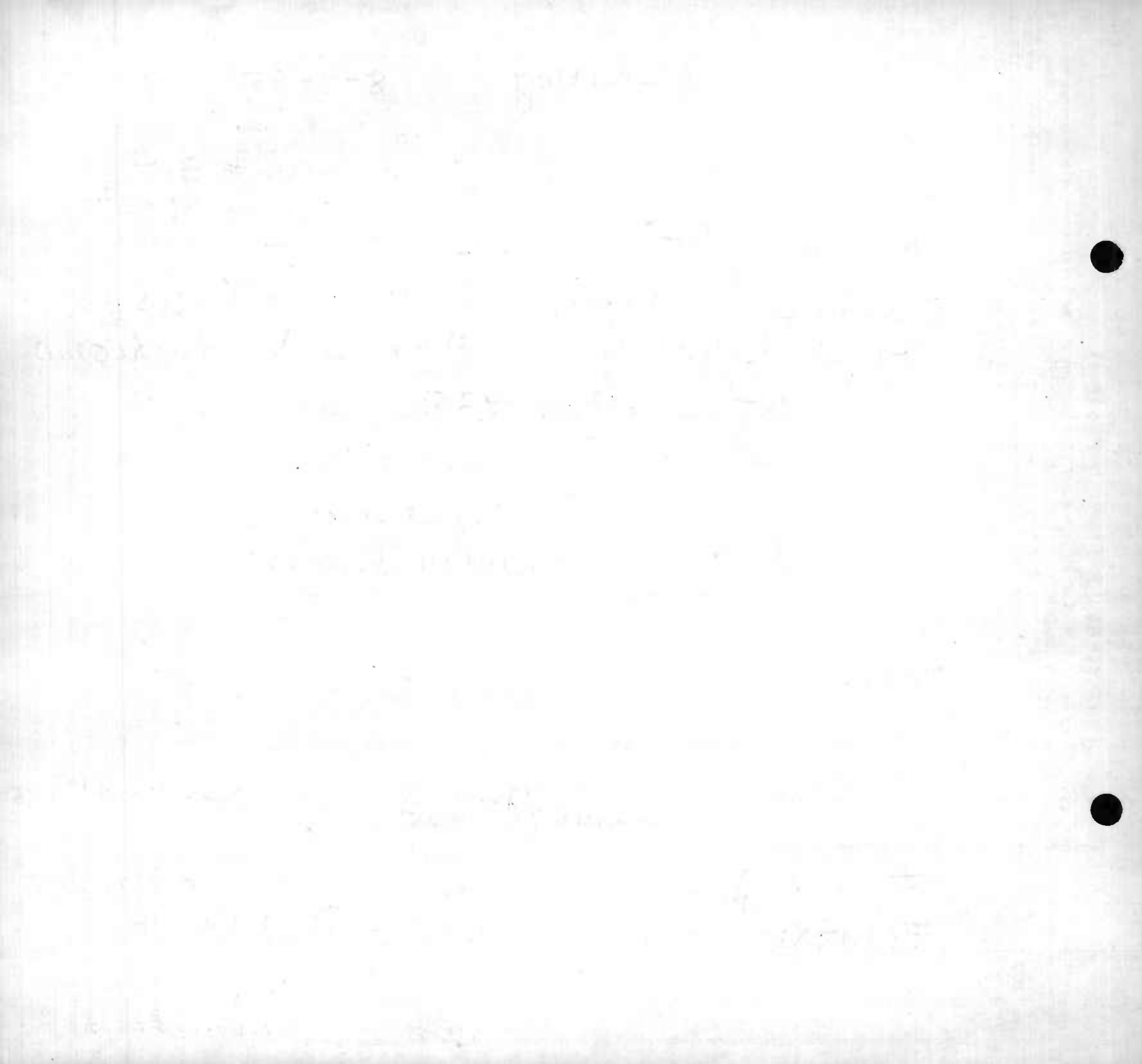
BIRTH NO. 65 8176		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8176	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Netcalf, Wilbur</i>		2. DATE AND HOUR OF DEATH <i>8-6-65</i>		12 ³⁰ AM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>MARYLAND UNIVERSITY HOSPITAL</i> 8/17/65		A. STATE <i>Md.</i> B. COUNTY <i>Balto 11</i>		13-05	
CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto 11</i>		D. STREET ADDRESS (If rural, give location) <i>3239 Chestnut Ave</i>			
5. SEX <i>MALE</i>		6. RACE <i>WHITE</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widower</i>	
8. DATE OF BIRTH <i>9/16/90</i>		9. AGE (In years last birthday) <i>74</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Machinist-helper</i>		11. BIRTHPLACE (State or foreign country) <i>Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>William Netcalf</i>		14. MOTHER'S MAIDEN NAME <i>Rosa Shipley</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>215-03-7883</i>		17. INFORMANT <i>EMMA</i> ADDRESS <i>3239 Chestnut Ave</i>	
18. <i>147X+1260X</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Internal hemorrhage</i> DUE TO		<i>Unmed</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Metastatic (?) Ca lung</i> DUE TO			
		(C) <i>Ca pyram sinus (?) 2yrs</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>pneumonia, diabetes mellitus</i>		19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7-1-1965</i> to <i>8-6-1965</i> , that (I) (we) last saw the deceased alive on <i>8-5-1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Nicholas C Busch</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8-6-65</i>			
23C. PHYSICIAN'S NAME (Type) <i>George H. Yeager</i> M.D.		23D. ADDRESS <i>212 Ridgewood rd, Balto</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>8-9-65</i>		24C. NAME OF CEMETERY OR CREMATORY <i>ARMED RIDGE</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTO MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 9 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>Paul E. Brown</i>		25D. ADDRESS <i>3239 Chestnut Ave</i>			

policy # 5926440 from John Hancock Insurance Company. 9/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
65 8177					CERTIFICATE OF DEATH					Registered No. 65 8177				
BIRTH NO.					1. NAME OF DECEASED (Type or Print) <u>James Richard Chaney</u>					2. DATE AND HOUR OF DEATH <u>8-7-65</u> <u>7:00 a.</u> M.				
M.E. CASE NO.					3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>Home</u>					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>md</u> B. COUNTY <u>21-02</u>				
FULL NAME OF HOSPITAL OR INSTITUTION <u>833 W. Cross St</u>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore #30</u>					D. STREET ADDRESS (If rural, give location) <u>833 W-Cross Street</u>				
5. SEX <u>M</u>		6. RACE <u>W</u>		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (Specify)		8. DATE OF BIRTH <u>3-17-05</u>		9. AGE (In years last birthday) <u>60</u>		If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>ref (auto)</u>					11. BIRTHPLACE (State or foreign country) <u>Anne Arundel County md</u>				
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					13. FATHER'S NAME <u>Richard Chaney</u>					14. MOTHER'S MAIDEN NAME <u>Anna W. Stinchcomb</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>					16. SOCIAL SECURITY NO. <u>213-34-4356</u>					17. INFORMANT <u>Margaret Chaney-Ch...</u>				
18. <u>581.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>liver cirrhosis</u>					CAUSE OF DEATH (A) DUE TO <u>hepatic coma</u>					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>arteriosclerosis</u>					(B) DUE TO					(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION <u>none</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>/</u>					20A. AUTOPSY? (Yes or No) <u>/</u>				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>/</u>					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?					22. I certify that (I) (this hospital) attended the deceased from <u>July 10, 1965</u> to <u>July August 7, 1965</u> that (I) (we) lost saw the deceased alive on <u>August 7, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Franz X. Groll</u>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED <u>8-7-65</u>				
23C. PHYSICIAN'S NAME (Type) <u>Franz Xaver Groll</u>					M.D. ADDRESS <u>1202 St. Paul Street</u>									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>8-9-65</u>					24C. NAME OF CEMETERY or CREMATORY <u>Epiphany Cem</u>				
24D. LOCATION (City, town, or county) (State) <u>Odenton, Md</u>					25A. DATE REC'D BY HEALTH DEPT. <u>AUG 9 1965</u>					25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>				
25C. FUNERAL DIRECTOR <u>Robert A. Banar</u>					ADDRESS <u>1202 St. Paul Street</u>									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

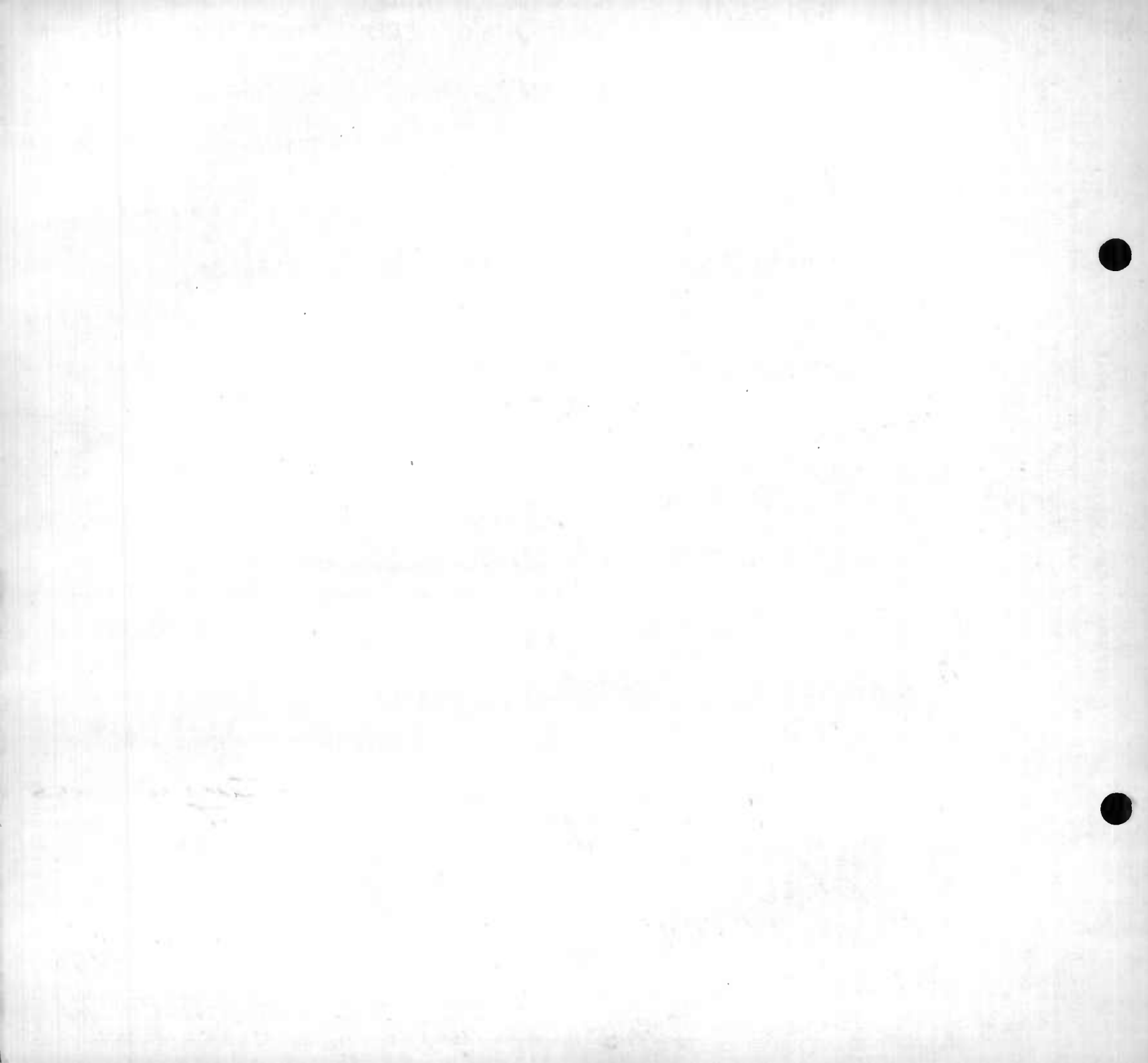
Baltimore City Health Department				Registered No. 65 8178	
BIRTH NO. 65 8178		CERTIFICATE OF DEATH			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ARTHUR MARTIN BRADY		2. DATE AND HOUR OF DEATH Aug. 4, 1965 9:20 p. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 FRANKLIN SQUARE HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 19-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 112 S. STRICKER ST			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NOT MARRIED	8. DATE OF BIRTH 6-29-04	9. AGE (In years last birthday) 61	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY City		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MARTIN BRADY		14. MOTHER'S MAIDEN NAME CLARA (?)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-05-6339		17. INFORMANT Hospital Records	
18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) cerebral edema DUE TO (B) cerebral hemorrhage DUE TO (C) hypertension		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-4 19 65 to 8-4 19 65 , that (I) (we) last saw the deceased alive on 8-4-65 (9 pm) and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE JANE V. DEL PILAR		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) JANE V. DEL PILAR		23D. ADDRESS Franklin Sq Hos Park Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/65		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem	
24D. LOCATION (City, town, or county) Belts Md		(State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR John E. Fairbank		25C. FUNERAL DIRECTOR Thomas J. Henry Jr	
				ADDRESS Belts Md	

2012. 12. 20

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

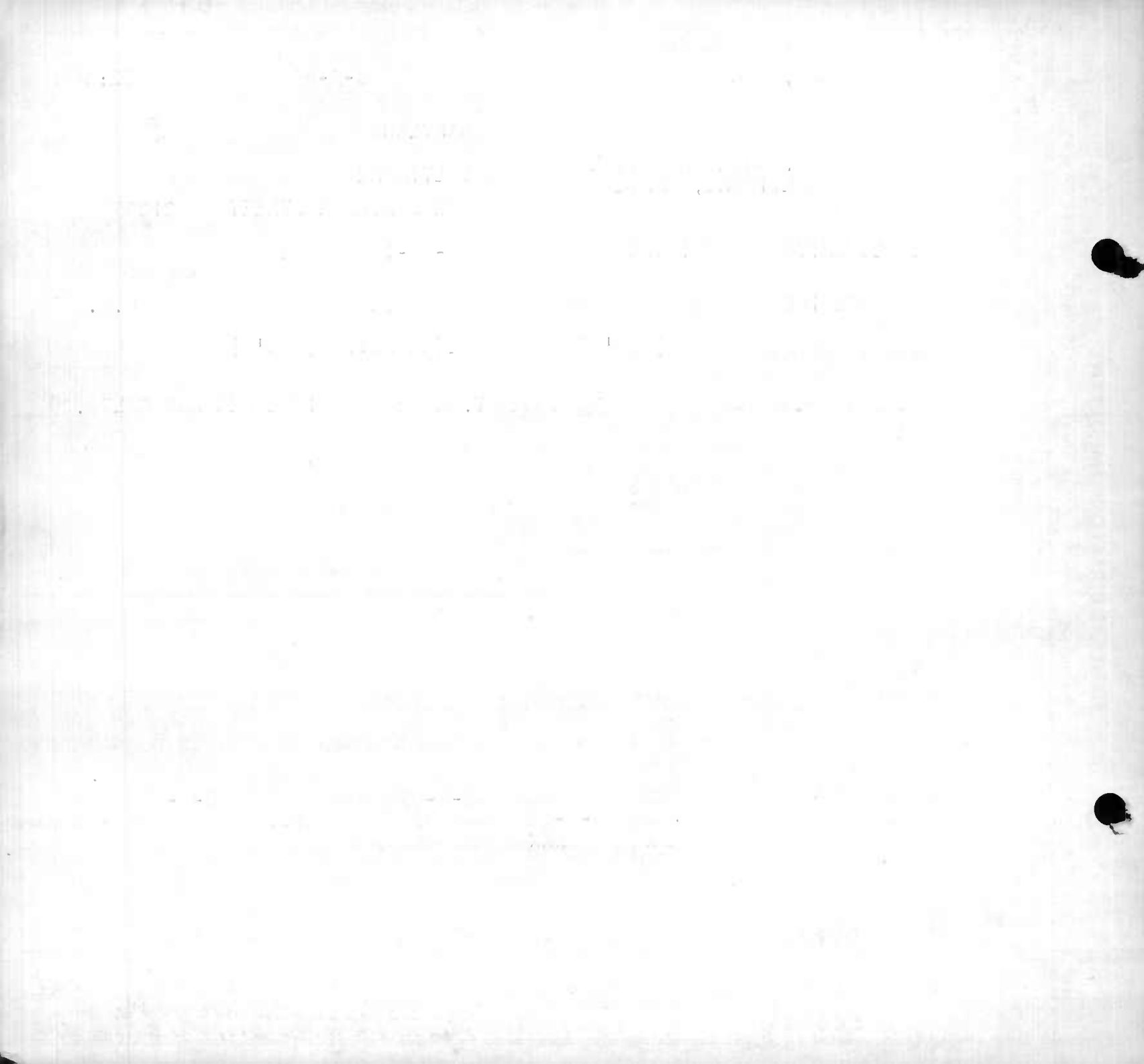
BIRTH NO. 65 8179		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8179	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>FRANCES Anna Ripley</i>		2. DATE AND HOUR OF DEATH <i>August 4, 1965 6:30 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>307 S. Bentalow St.</i>		A. STATE <i>MARYLAND</i> B. COUNTY <i>20-05</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> D. STREET ADDRESS (If rural, give location) <i>307 S. Bentalow St.</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>Nov. 28 1900</i>	9. AGE (In years last birthday) <i>64</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>John W. WALL</i>			14. MOTHER'S MAIDEN NAME <i>Anna P. Hammond</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT ADDRESS <i>213-05-9946B LAWRENCE Ripley 307 S. Bentalow St.</i>	
18. <i>199.21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Metastatic Carcinoma</i> DUE TO (B) <i>Carcinoma of Ovary</i> DUE TO (C) <i>and Peritonium</i>		INTERVAL BETWEEN ONSET AND DEATH <i>57</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>Sept 1964</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma</i>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 1965</i> to <i>Aug 4-1965</i> , that (I) (we) last saw the deceased alive on <i>Aug 4-1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.					
23A. SIGNATURE <i>Charles A. Cahn</i> M.D.				23B. DATE SIGNED <i>8/6-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Charles A. CAHN</i>		23D. ADDRESS <i>2145 W. Baltimore St Baltimore</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>8-7-65</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 9 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <i>Geo. L. Schwab Funeral Home</i>			
25D. ADDRESS <i>Francis W. Miller 2101 Frederick Ave</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

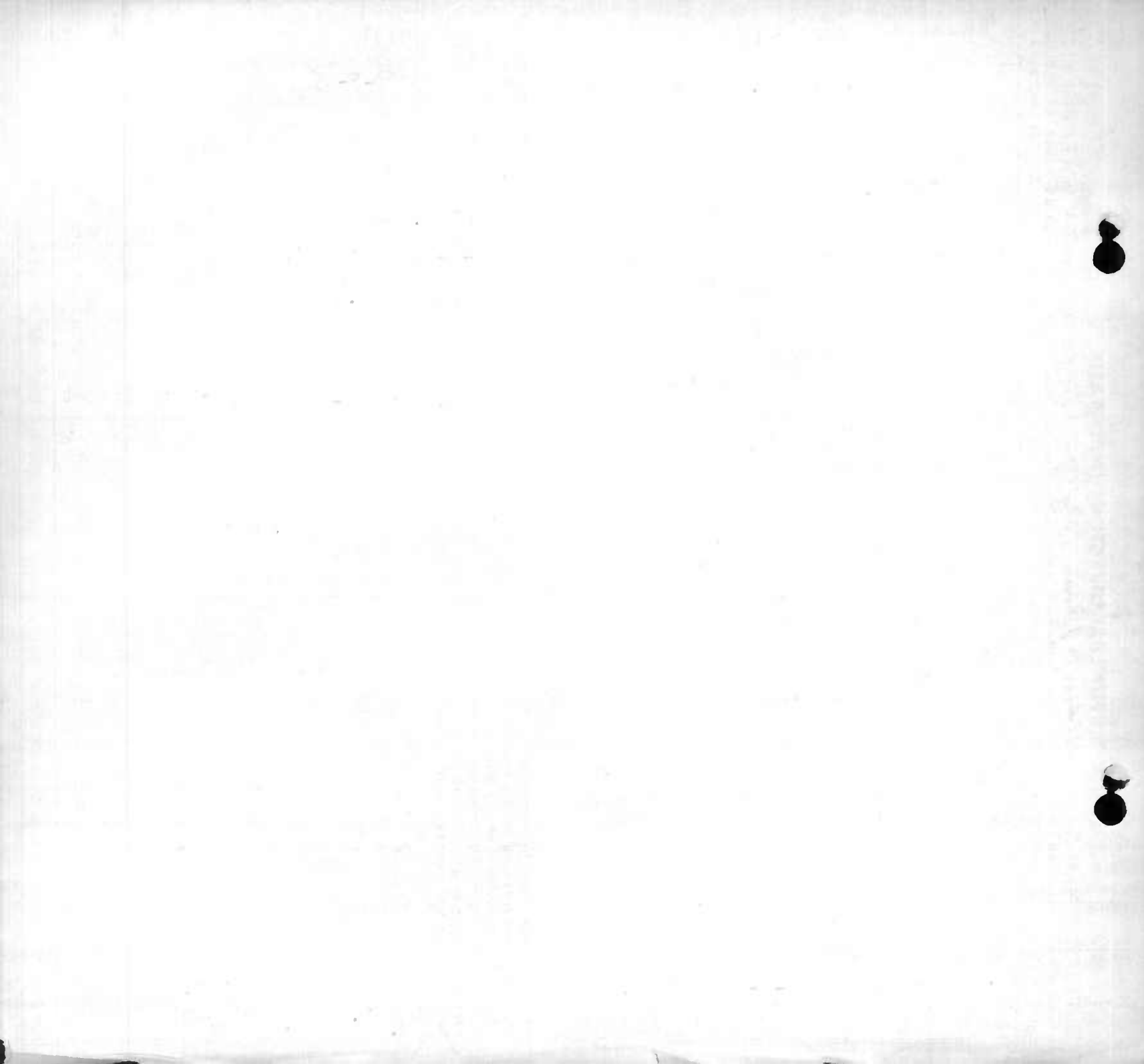
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 8180					CERTIFICATE OF DEATH			Registered No. 65-8180	
1. NAME OF DECEASED (Type or Print) HAHN, EVA					2. DATE AND HOUR OF DEATH 8-5-65 12:45AM M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 20-03				
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL BALTIMORE, MARYLAND					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
					D. STREET ADDRESS (If rural, give location) 602 S MONROE STREET 21223				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED		8. DATE OF BIRTH 12-19-10	9. AGE (In years lost birthday) 54	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Edwin Durborow. (DEC'D)					14. MOTHER'S MAIDEN NAME LENA SMITH (DEC'D)				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN NONE			16. SOCIAL SECURITY NO. 215-05-6266		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS BALTO. 29				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 15-6-21 metastatic ca Liver GI hemorrhage ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (X) (this hospital) attended the deceased from 8-4-65 19 to 8-5-65 19, that (X) (we) last saw the deceased alive on 8-5-19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Vicente G. Rubien M.D.					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 8-5-65	
23C. PHYSICIAN'S NAME (Type) VICENTE G. RUBIEN M.D.					23D. ADDRESS ST. AGNES HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-9-65		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill			24D. LOCATION (City, town, or county) (State) Anne Arundel City Md.		
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1965			25B. NAME OF REGISTRAR Robert E. Jenkins			25C. FUNERAL DIRECTOR GEO. L. SCHWAB, Funeral Home Francis & Agathe 2101 Frederick Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 8181	
BIRTH NO. 65 8181		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Howard L. Brooks		2. DATE AND HOUR OF DEATH 8-5-65 8 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 23-01			
FULL NAME OF HOSPITAL OR INSTITUTION 103 W. Henrietta Street		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 103 W. Henrietta Street	
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 8-1-95	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) L		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Calvert Co., Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Peter F Brooks				14. MOTHER'S MAIDEN NAME Johana			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mary Brooks-103 W. Henrietta Street		ADDRESS	
18. 201 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CORONARY ARTERY OCCLUSION				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) ARTERIOSCLEROTIC C+V DIS.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/2/65 to 8/7/65 , that (I) (we) last saw the deceased alive on 8/2/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John S. Braxton Jr.				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/7/65	
23C. PHYSICIAN'S NAME (Type) JOHN S. BRAXTON JR.		23D. ADDRESS 922 S. SHARP, BALT. 30, MD					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-9-65		24C. NAME OF CEMETERY or CREMATORY Baltimore, National Ct		24D. LOCATION (City, town, or county) (State) Baltimore, City.	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Isaiah L. Brown and Son		ADDRESS 108 W. Montgomery Street	



BIRTH NO.

65 8182

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JUANITA

GRAVES

2. DATE AND HOUR PRONOUNCED DEAD

August 5, 1965

1:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1501 Tenpin Alley

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ma

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Charles Comper

14. MOTHER'S MAIDEN NAME

Mrythle Bowman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Shirley Spence 2249 E. Chase St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple Traumatic Injuries.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

1501 Tenpin Alley

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8 2 '65 P21E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fall from second floor window.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/5/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-9-65

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Ct

23D. LOCATION

(City, town, or county)

(State)

A.A.CO., Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 9 1965

Robert E. Farkas

Isaiah L. Brown and Son
108 W. Montgomery Street

WALLEY FORDGE

WALLEY FORDGE

WALLEY FORDGE

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FUNERAL DIRECTOR: IMPORTANT

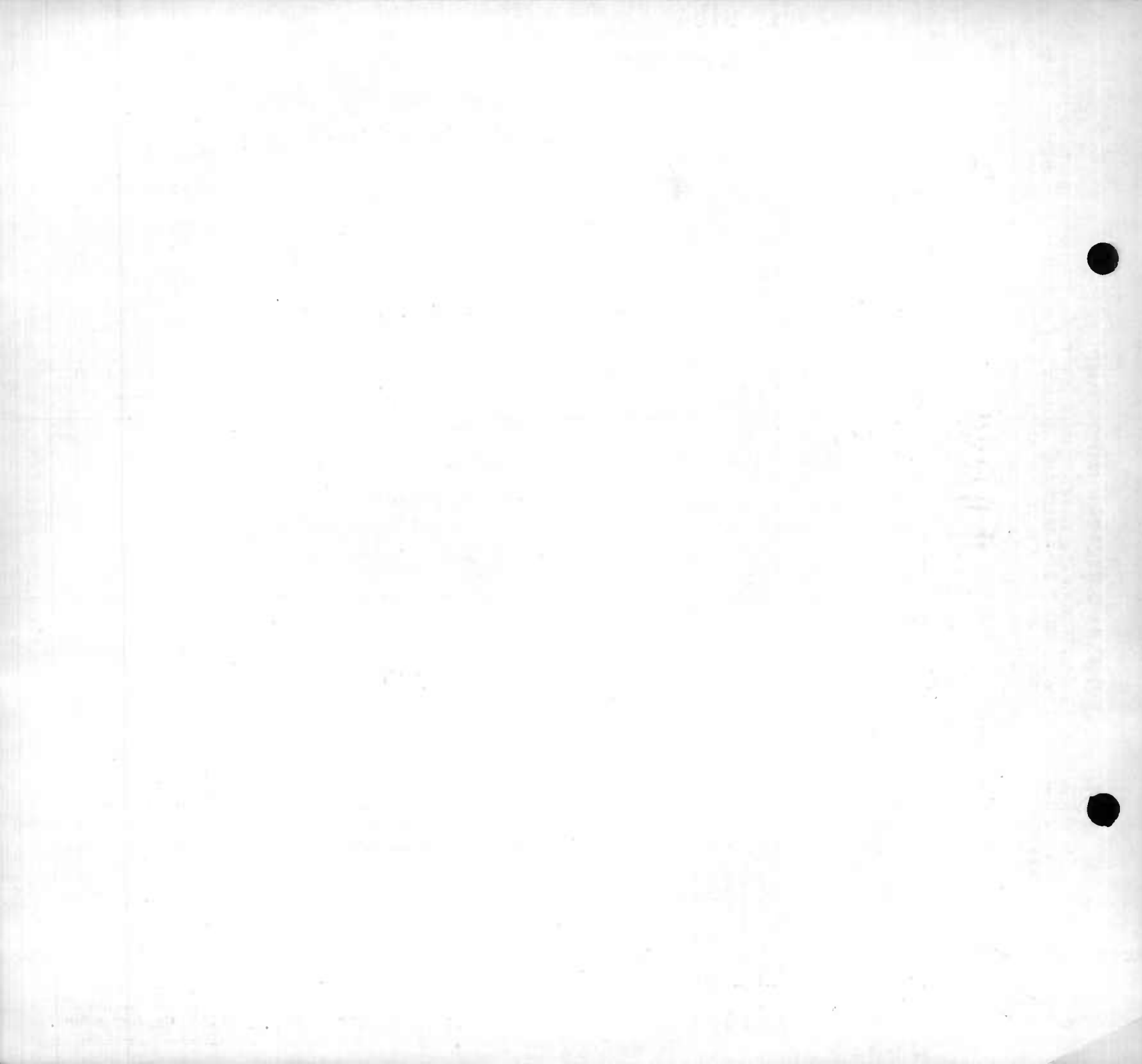
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8183				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8183			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>James Hollie</i>				2. DATE AND HOUR OF DEATH <i>8/2/65 11⁰⁰ a.m.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md</i> B. COUNTY <i>25-32</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE 25</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University Hospital BALTIMORE 1, md</i>				D. STREET ADDRESS (If rural, give location) <i>3316 Cherryland Rd</i>							
5. SEX <i>m</i>	6. RACE <i>c</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>widowed</i>	8. DATE OF BIRTH <i>11/29/98</i>	9. AGE (In years last birthday) <i>66</i>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>md.</i>			
12. CITIZEN OF WHAT COUNTRY <i>USA</i>				13. FATHER'S NAME <i>Joseph Hollie</i>				14. MOTHER'S MAIDEN NAME <i>Nora Cole</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <i>Harvett Under</i> ADDRESS <i>same.</i>			
18. <i>153.3 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Ca of sigmoid colon</i> DUE TO (B) <i>metastases to liver & lungs.</i> DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <i>8/2/65</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ca of colon</i>				20A. AUTOPSY? (Yes or No) <i>yes</i>			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?				22. I certify that (1) (this hospital) attended the deceased from <i>7 hr</i> 19 <i>65</i> to <i>8 hr</i> 19 <i>65</i> that (1) (we) last saw the deceased alive on <i>8/2/65</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>R M Byers</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>8/2/65</i>				23C. PHYSICIAN'S NAME (Type) <i>R M Byers</i> M.D.			
23D. ADDRESS				24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>8/7/65</i>			
24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral</i>				24D. LOCATION (City, town, or county) (State) <i>Balto City</i>				25A. DATE REC'D BY HEALTH DEPT. <i>AUG 9 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Farley</i>				25C. FUNERAL DIRECTOR <i>J. J. Brown</i> ADDRESS <i>108 W. Hunt...</i>							

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8184				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8184	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				KATHERINE HARMAN		Aug. 7, 1965 3:00 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
Maryland Gen. Hospital				Maryland		1-04	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				D. STREET ADDRESS (If rural, give location)			
				227 Fleet St.			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED		8. DATE OF BIRTH	
F		W		WIDOWED, DIVORCED (specify)		11-2-81	
9. AGE (In years last birthday)		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
83		Own Home		Baltimore, Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
?				?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No						Alberta Stokes - same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
331X I				Cerebro Vascular			
ANTECEDENT CAUSES				(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 7-27-1965 to 8-7-1965 that (I) (we) last saw the deceased alive on 8-7-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Robert E. Jakes				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		8-7-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8-10-1965		Oak Lawn		Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
AUG 9 1965		Robert E. Jakes		Lilly & Zeiler Inc. 1901 Eastern Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8185
BIRTH NO. 65-8185		CERTIFICATE OF DEATH		
M.E. CASE NO. 65-8185		1. NAME OF DECEASED COURTENAY JEMIFER		2. DATE AND HOUR OF DEATH AUGUST 4, 1965 7:25P.M.
1. NAME OF DECEASED (Type or Print) HERCULES COURTNEY JEMIFER		2. DATE AND HOUR OF DEATH AUGUST 4, 1965 7:25P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED		4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		A. STATE MD. B. COUNTY BALTIMORE		
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) RURAL TIMONIUM 21093		
		D. STREET ADDRESS (If rural, give location) JEMIFER RD.		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH DEC 11, 1884	9. AGE (In years last birthday) 80
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTORNEY	10B. KIND OF BUSINESS OR INDUSTRY LAW	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME THOMAS R. JEMIFER		14. MOTHER'S MAIDEN NAME MARGARET MOORE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK. none		16. SOCIAL SECURITY NO. UNK. 215-30-4155		17. INFORMANT ADDRESS MRS. ILMA JEMIFER SAME
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) BILATERAL PNEUMONIA		
ANTECEDENT CAUSES		(B) CONGESTIVE FAILURE		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (we) (this hospital) attended the deceased from AUGUST 3 1965 to AUGUST 4 1965 , that (we) last saw the deceased alive on AUGUST 4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.				
23A. SIGNATURE L. Evan Custer, M.D.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED AUGUST 4, 1965
23C. PHYSICIAN'S NAME (Type) DR. L. EVAN CUSTER		23D. ADDRESS M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Aug. 7, 1965	24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery	24D. LOCATION (City, town, or county) (State) Piksville, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965	25B. NAME OF REGISTRAR Robert E. Fawcett	25C. FUNERAL DIRECTOR ADDRESS John Burns Son, Towson, Md.		

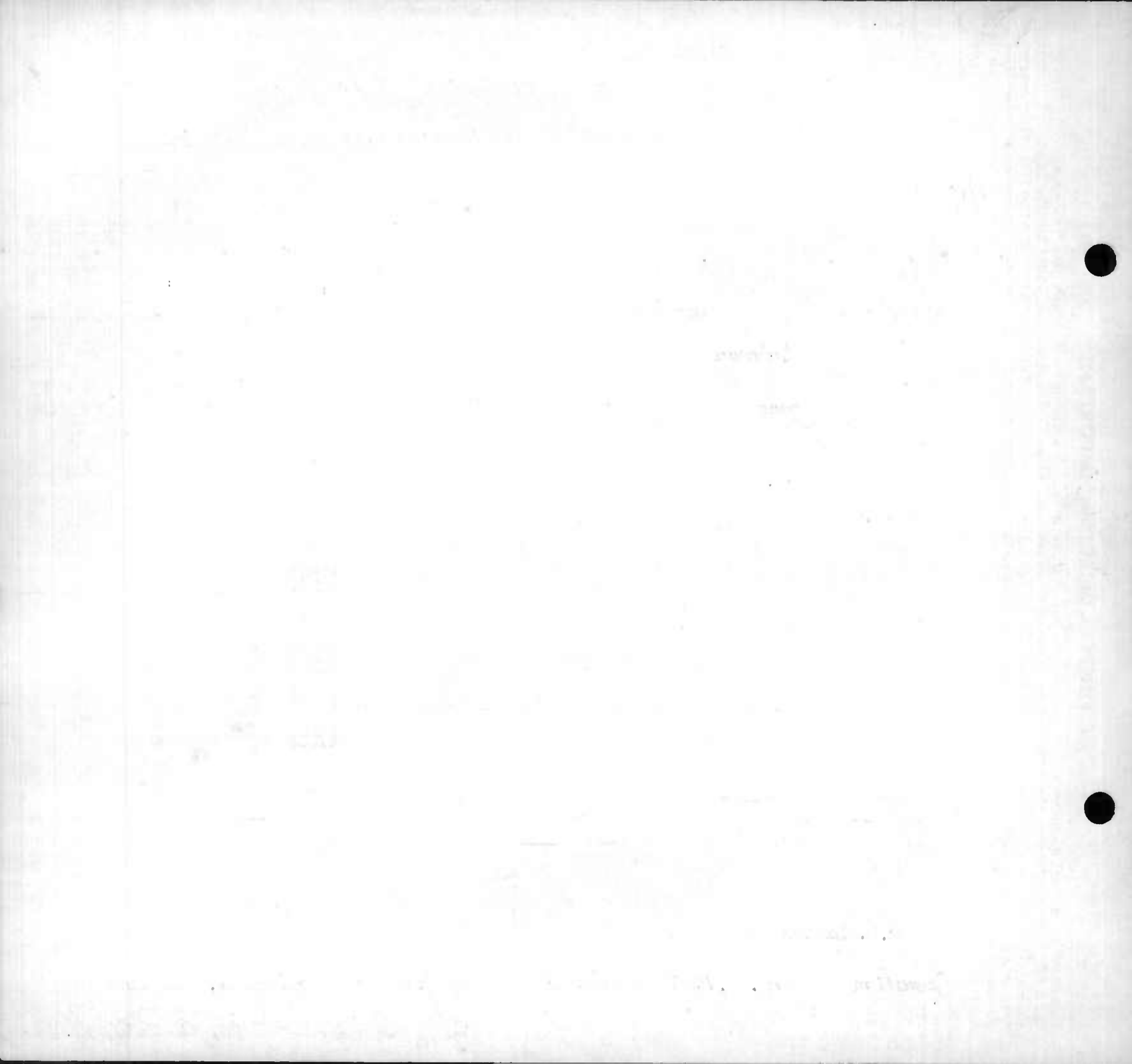
vs 153 completed by funeral director. 8/16/65

EXHIBIT C-1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

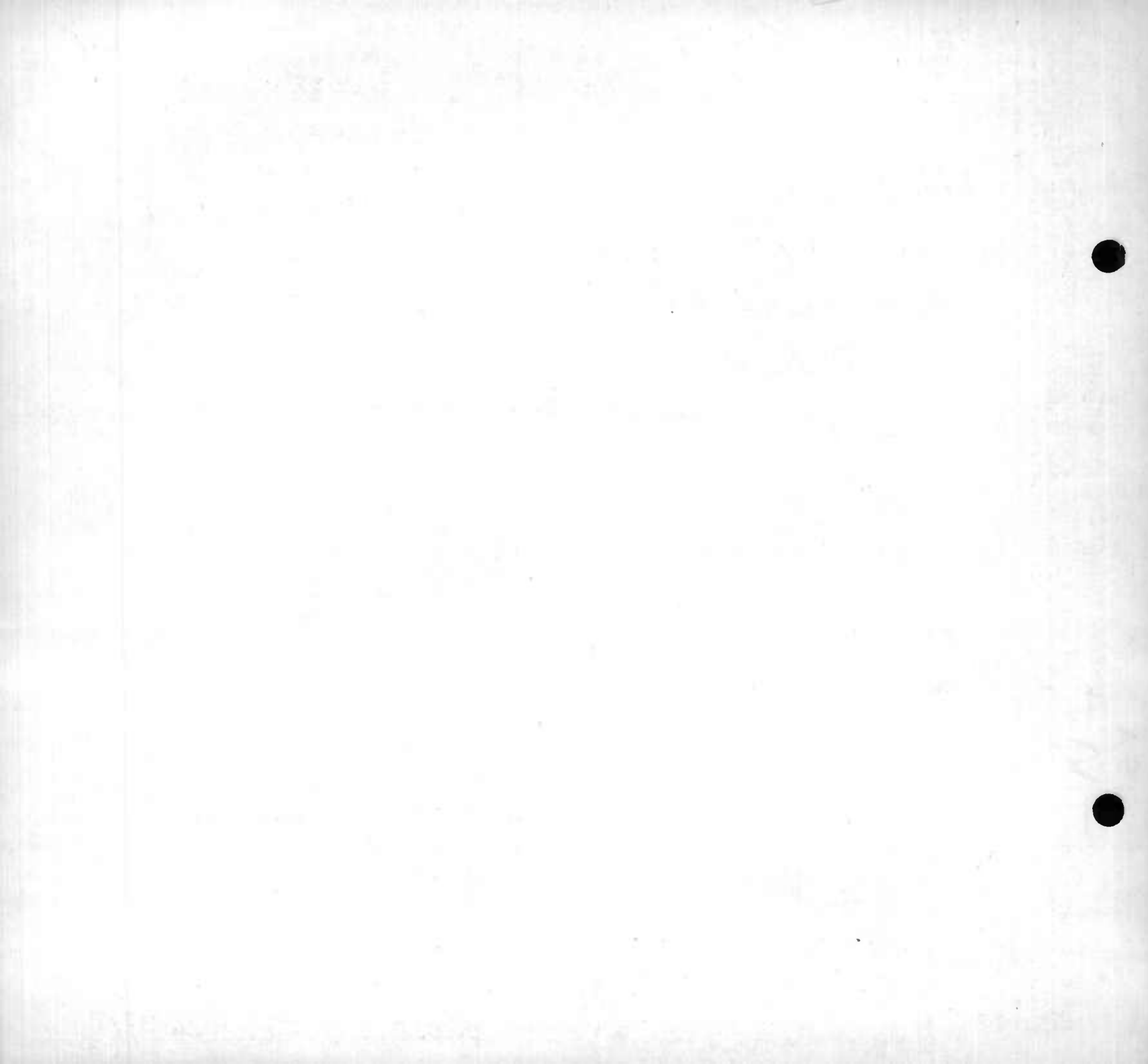
BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. 65 8186					
BIRTH NO. 65 8186					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) KATHRYN SCOTT COSTLOW					2. DATE AND HOUR OF DEATH 8/4/65 6:00 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 411 UNION MEMORIAL HOSPITAL					A. STATE MARYLAND					
					B. COUNTY Balto					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					
					D. STREET ADDRESS (If rural, give location) 915 SOUTHERLY RD. 4					
5. SEX FEMALE		6. RACE CAU.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 11/16/87		9. AGE (In years last birthday) 78		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME ? Unknown					14. MOTHER'S MAIDEN NAME MARGARET ANDERSON (?)					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO none					16. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS 227 Sandee Rd. MRS. MORAL McDONALD/TIMONIN			
18. 15381 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH					
ANTECEDENT CAUSES					INTERVAL BETWEEN ONSET AND DEATH 14d					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) - Diffuse adenocarcinomatous -					
					(B) - primary - large bowel.					
					(C) - post					
II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 2/12/65 to 8/4/65, that (I) last saw the deceased alive on 8/4/65 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.										
23A. SIGNATURE W.R. Linton, Jr.						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/4/65		
23C. PHYSICIAN'S NAME (Type) W.R. Linton						23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation			24B. DATE Aug. 7, 1965			24C. NAME OF CEMETERY or CREMATORY Greenmount Cemetery Crematory			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965			25B. NAME OF REGISTRAR Robert E. Fisher			25C. FUNERAL DIRECTOR John Burns' Sons, Towson, Md.			ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 8187	
BIRTH NO. 65 8187		M.E. CASE NO. 65 8187		1. NAME OF DECEASED (Type or Print) HOWARD E. STREAKER		2. DATE AND HOUR OF DEATH AUGUST 6, 1965 8:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY 13-06	
825 WELLINGTON ST.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 825 WELLINGTON ST			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH DECE. 19/81	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TECHNICAL MGR. CAN COMPANY		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE MD		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME FRANK STREAKER				14. MOTHER'S MAIDEN NAME SUSAN ALLISON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE		16. SOCIAL SECURITY NO. 216-05-1737		17. INFORMANT MRS GLADYS WOLFGANG PIKE HORST		ADDRESS 6028 RD.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) Coronary occlusion seconds			
ANTECEDENT CAUSES				(B) Hypertension c-v disease years			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Severe anxiety & depression 1 month.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1962 to 8/6/65 19 that (I) (we) lost saw the deceased alive on 8/5/65 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death,							
23A. SIGNATURE Philip Whittleson				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/7/65	
23C. PHYSICIAN'S NAME (Type) Philip Whittleson				23D. ADDRESS 600 W. Belvedere, Balto.			
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE AUG 9/65		24C. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY		24D. LOCATION (City, town, or county) BALTIMORE CO. MD	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Philip E. Donovan		ADDRESS 3818 Roland Ave	



BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

KENNETH BUTLER

2. DATE AND HOUR PRONOUNCED DEAD

August 3, 1965 3:25 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2560 Marbourne Avenue

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never married

8. DATE OF BIRTH

3/14/65

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

5

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

--

10B. KIND OF BUSINESS OR INDUSTRY

--

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Harold L. Butler

14. MOTHER'S MAIDEN NAME

Thelma V. Collins

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

--

16. SOCIAL
SECURITY NO.

--

17. INFORMANT

ADDRESS

Mr. Harold Butler 2560 Marbourne Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Interstitial pneumonitis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-4-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/6/65

23C. NAME of CEMETERY or CREMATORY

Glen Haven Mem. Pk.

23D. LOCATION

(City, town, or county)

(State)

Glen Burnie, Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 9 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

JOHN F. DENNY, INC. 715 Light St.

ADDRESS

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JUN 10 1964

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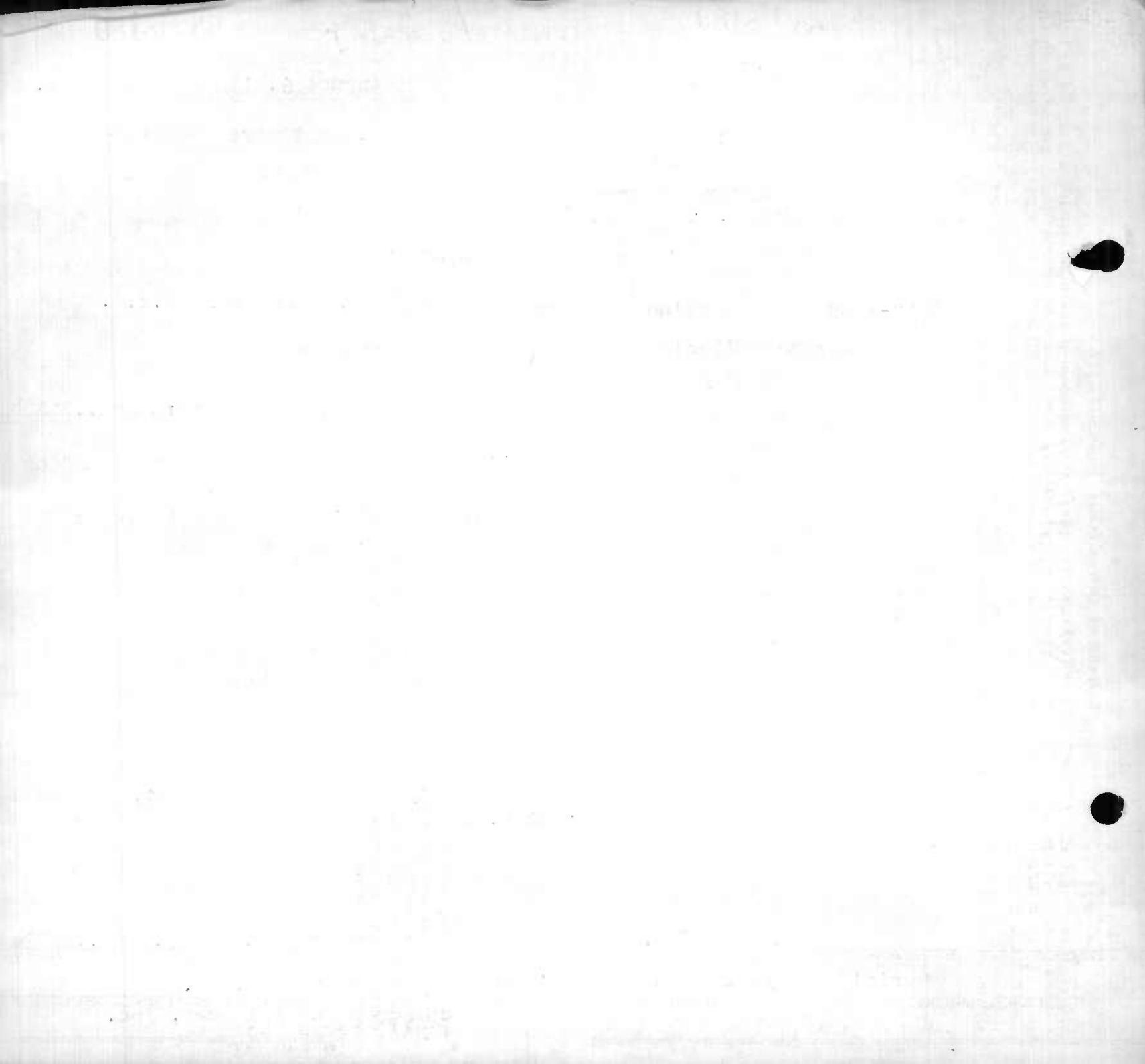
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FUNERAL DIRECTOR: IMPORTANT

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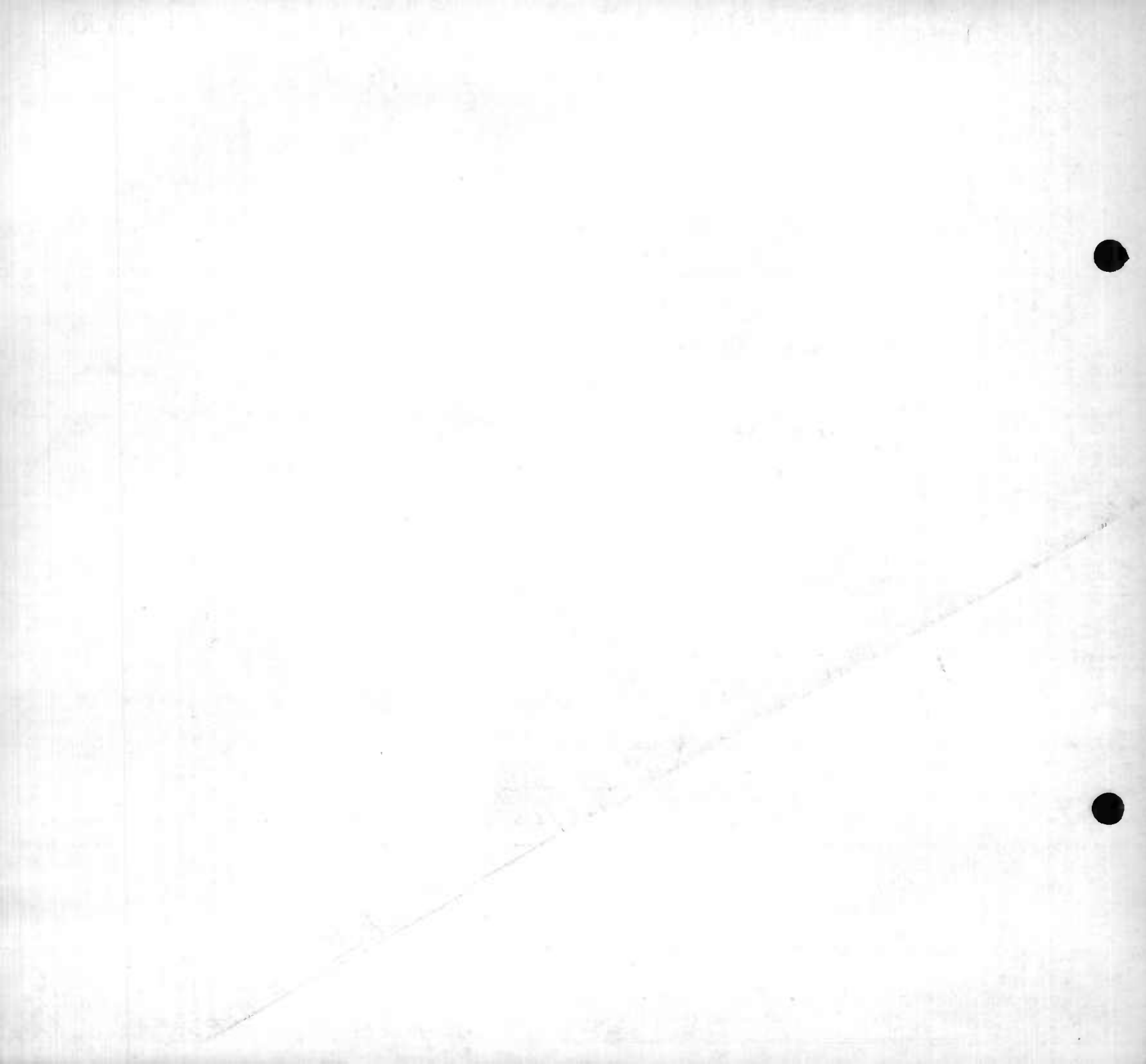
BIRTH NO.		65 8189		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8189	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Mary Margaret Bohle				August 6, 1965 18:45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland, #21224				Maryland, Baltimore Zone 22			
5. SEX Female				6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Char-lady				Belnord Theatre		4-5-1893	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
Abraham Wilhelm				unknown		72	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)	
						Maryland, Baltimore	
17. INFORMANT				12. CITIZEN OF WHAT COUNTRY?			
ADDRESS				U.S.A.			
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) Cirrhosis			
ANTECEDENT CAUSES				(B) Diabetes Mellitus			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2						Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from July 25, 19 65 to August 6, 19 65, that (I) (we) last saw the deceased alive on August 6, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> 1		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS		August 6, 1965	
DR. Howard K. Rathbun M.D.				4940 Eastern Avenue, Balto., Md., 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/9/65		Oak Lawn Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 9 1965		Robert E. Faldut		Schimunek Funeral Home, Inc.		73331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8190		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 8190	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Stella Florence Hance</i>			2. DATE AND HOUR OF DEATH <i>7/29/65</i> <i>6:25 P M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>38 University Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>Anne Arundel</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Jessup</i> D. STREET ADDRESS (If rural, give location) <i>P.O. Box 20</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W</i>	8. DATE OF BIRTH <i>2/2/82</i>	9. AGE (In years lost birthday) <i>83</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HW</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Abraham Slade</i>			14. MOTHER'S MAIDEN NAME <i>Elizabeth Ridley</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220 44 1860</i>	17. INFORMANT <i>Elizabeth Summers Laurel Md</i>		
18. <i>420.14-151X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Deep femoral Vein Thrombosis</i> <i>Coccyx of The Spine.</i>			CAUSE OF DEATH (A) <i>Myocardial Infarction</i> DUE TO (B) <i>Acute Ventricular Fibrillation</i> DUE TO (C) <i>Arteriosclerotic Heart Disease</i> INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <i>7/26</i>		19B. OPERATION FOR WHICH OPERATION WAS PERFORMED <i>Deep femoral Thrombosis</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7/9/65</i> 19 to <i>7/29/65</i> 19 that (I) (we) last saw the deceased alive on <i>7/29/65</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Philip A. Insley</i>			23B. DATE SIGNED <i>7/27/65</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <i>Philip A. Insley</i>			23D. ADDRESS <i>University Hospital</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>8-2-65</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Colmar Manor Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 9 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Deputy Donaldson Laurel Md</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8191				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8191	
M.E. CASE NO.				FOUNTAIN		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>FOUNTAIN/LOLA R. STANSFIELD</i>				Lola R. Stansfield		<i>8/3/65 4:30 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Franklin Square Hospital</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 25, A.A. CO. Brooklyn</i>		D. STREET ADDRESS (If rural, give location) <i>228 Davis Ave. 52-00</i>	
CERTIFICATE AMENDED							
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>4/14/09</i>	9. AGE (In years last birthday) <i>58 yrs.</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
13. FATHER'S NAME <i>Franklin Stansfield</i>			14. MOTHER'S MAIDEN NAME <i>Virginia Johnson</i>				
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Husband</i> ADDRESS <i>228 Davis Ave. Same</i>		
18. <i>199.2 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>BRUSHTYD CARCINOMATOSIS</i>				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>7 months</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION <i>6-21-65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>D</i>		20A. AUTOPSY? (Yes or No) <i>D</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>6-21-65</i> to <i>8/3-65</i> , that (I) (we) last saw the deceased alive on <i>8/3-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Johns. Scorg</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>Johns. Scorg</i>				23D. ADDRESS <i>Franklin Square Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-6-65</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Balto 25, MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 9 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>McCally</i>		ADDRESS <i>237 Patapsco Ave.</i>	

vs. 153 signed by funeral director. 8/20/65

100-100000-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8192		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8192	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) Prinz, Ferdinand		
2. DATE AND HOUR OF DEATH 8/7/65 9:30 A.M.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 Franklin Square Hosp		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1903			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 229 S. Stricker St			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 12/29/194	9. AGE (In years last birthday) 70	10. CITIZEN OF WHAT COUNTRY? U.S.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taylor		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Rumania	
13. FATHER'S NAME John Prinz		14. MOTHER'S MAIDEN NAME BARBARA Beckar-Elizabeth Stibel		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) No No	
16. SOCIAL SECURITY NO. 215-32-3608		17. INFORMANT Hospital Reads		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Ca of Esophagus with Metastasis (B) DUE TO Pneumonia (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 18/3/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED poor		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/29 1965 to 8/7 1965, that (I) (we) last saw the deceased alive on 8/7 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Byong Koo Kim M.D.				23B. DATE SIGNED 8/7/65	
23C. PHYSICIAN'S NAME (Type) Byong Koo Kim M.D.				23D. ADDRESS Franklin Square Hosp	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 8/10/65		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cn	
24D. LOCATION (City, town, or county) Belts Md		24E. (State)		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965	
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Thomas J. Kenny Inc		ADDRESS Belts Md	

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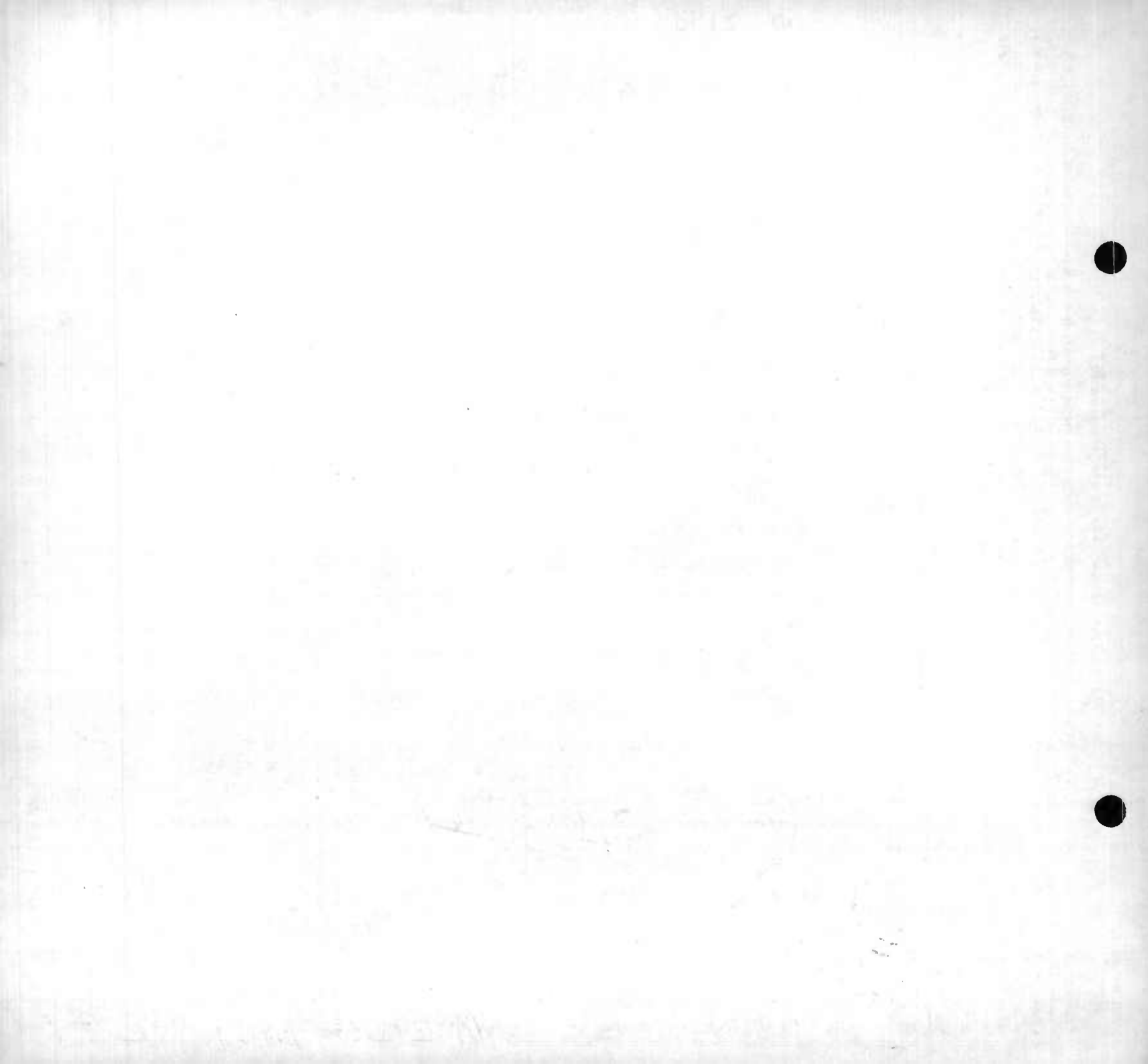
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

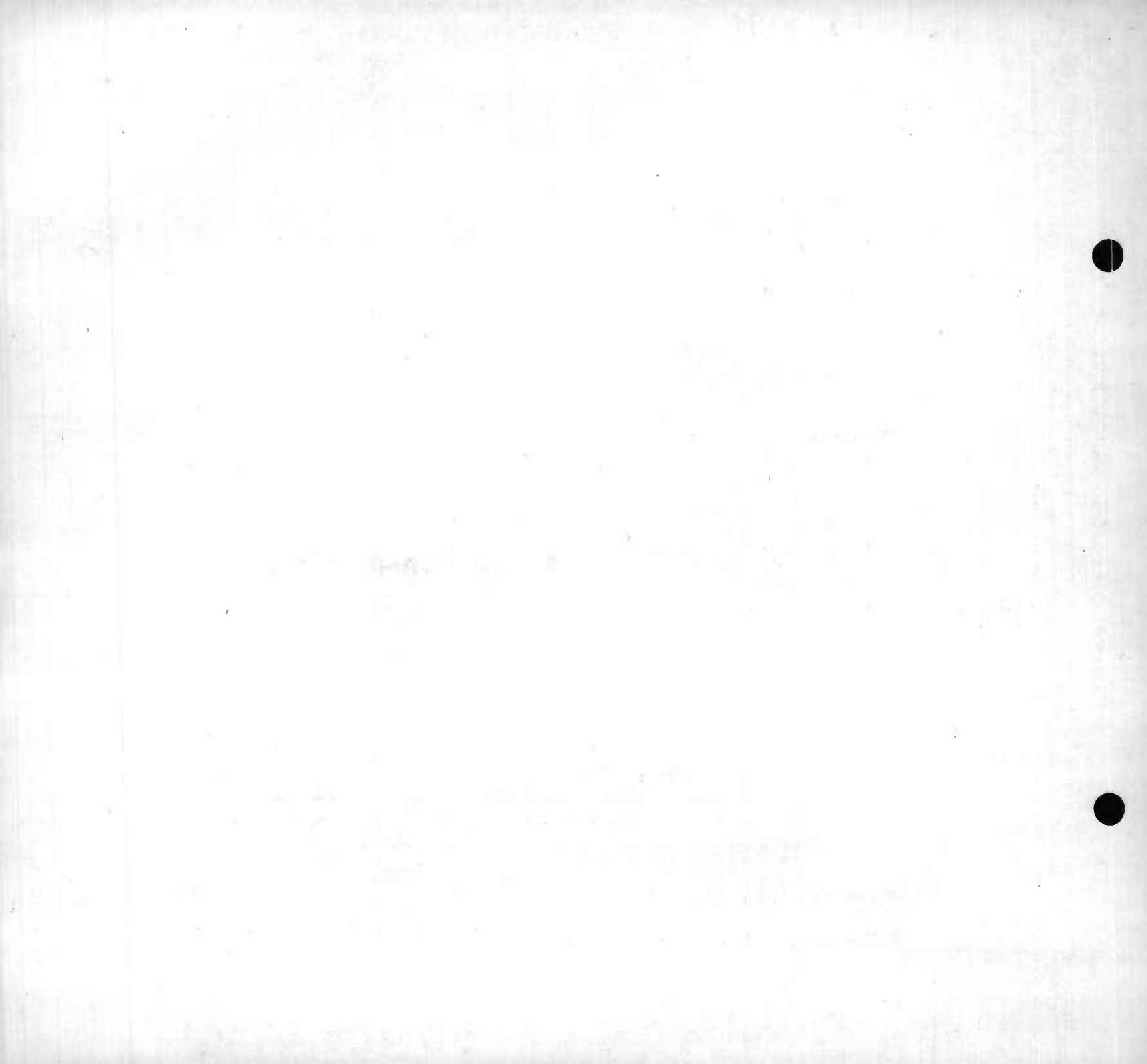
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8193	
BIRTH NO. 65 8193		CERTIFICATE OF DEATH			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MAMIE YOUNG			2. DATE AND HOUR OF DEATH 8-4-65 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 804 HOLLINS ST.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 15-38 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3401 FAIRVIEW AVE.		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 1882	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) ST. MARY'S Co., Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME ?		
14. MOTHER'S MAIDEN NAME ?(BROWN)			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. NONE			17. INFORMANT Robert Johnson ADDRESS 3401 FAIRVIEW		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 260X I Diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH 2		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 29 1965 to 9/4 1965 that (I) (we) last saw the deceased alive on 8/4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert Johnson M.D.			23B. DATE SIGNED 8/6-65		
23C. PHYSICIAN'S NAME (Type) Robert Johnson M.D.			23D. ADDRESS 1037 Madison Bg		
24A. BURIAL REMOVAL (Specify) BURIAL		24B. DATE 8-9-65		24C. NAME OF CEMETERY or CREMATORY ARBUTUS Cemetery	
24D. LOCATION (City, town, or county) (State) BALTO. County, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Marshall W. Jones, Jr. ADDRESS 1735 Ave. Harford			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

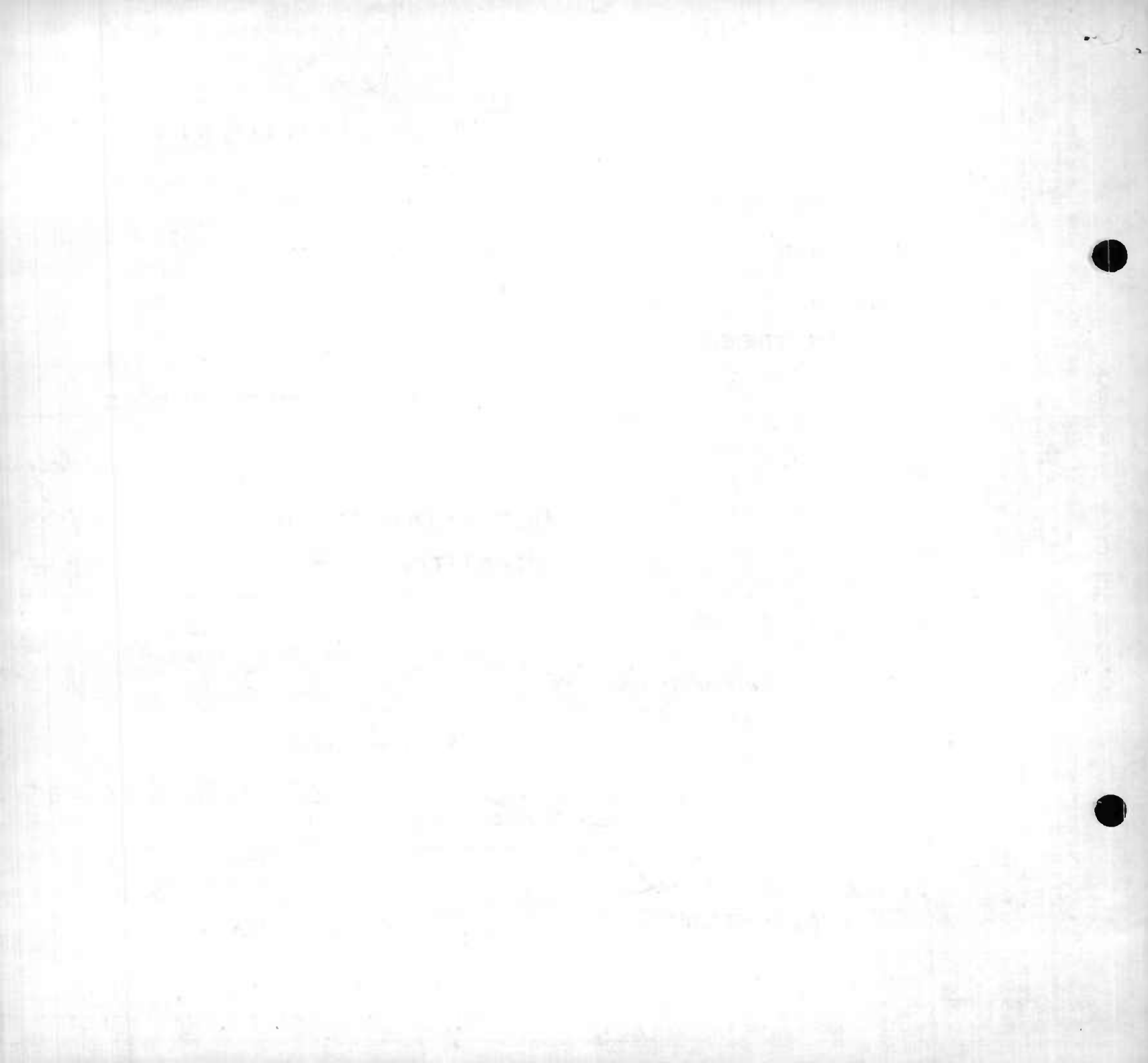
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 8194		CERTIFICATE OF DEATH				Registered No. 85 8194			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GEORGE H. MOELLER				2. DATE AND HOUR OF DEATH 8-1-65 9:20 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Bk. General Hosp					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, MD. D. STREET ADDRESS (If rural, give location) 3907 Annapolis Rd				
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Sept 14, 1887	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Police Dept.		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME George G. Moeller			14. MOTHER'S MAIDEN NAME Margaret			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.			17. INFORMANT Family			ADDRESS Same			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Coronary Thrombosis DUE TO (B) DUE TO (C) Coronary Arterio-Sclerosis		INTERVAL BETWEEN ONSET AND DEATH Immediate several years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0 None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ✓		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Jan. 2, 1963 to Aug. 1, 1965 , that (I) (we) last saw the deceased alive on Aug. 1, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Frank N. Ogden M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED Aug. 4, 1965				
23C. PHYSICIAN'S NAME (Type) FRANK N. OGDEN				23D. ADDRESS 2701 N. Calvert St.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-5-65		24C. NAME OF CEMETERY or CREMATORY Lorraine Cem		24D. LOCATION (City, town, or county) (State) Baltimore 7, MD			
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Mr. City of Baltimore		ADDRESS 237 Pennsylvania Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8195		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8195	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) BERTHA LEVINSON		
2. DATE AND HOUR OF DEATH 12¹⁰ AM AUG. 6 1965			M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE CITY		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSP. of BALTIMORE, INC.			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 3730 TOWANDA AVENUE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED MARRIED	8. DATE OF BIRTH 12/20/1912	9. AGE (In years lost birthday) 52	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) POLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME PAUL ROTHEUSER			14. MOTHER'S MAIDEN NAME SARAH ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT ADDRESS MR. SOL LEVINSON 3730 TOWANDA AVENUE	
18. 581.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) GASTRO-INTESTINAL HEMORRHAGE DUE TO (B) POST-HEPATITIC CIRRHOSIS DUE TO (C) HEPATITIS INTERVAL BETWEEN ONSET AND DEATH 1 day 6 yrs. 6 yrs.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 1960		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Liver Biopsy and Gall Bladder Suspected		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7³⁰ PM AUG 5 19 65 to 12¹⁰ AM AUG 6 19 65 , that (I) (we) last saw the deceased alive on 12¹⁰ AM AUG 6 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph Weinstock M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 8/6/65	
23C. PHYSICIAN'S NAME (Type) JOSEPH WEINSTOCK		23D. ADDRESS SINAI HOSP of BALTIMORE INC.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/6/65		24C. NAME of CEMETERY or CREMATORY MOSES MONTIFILORE WOODMOOR HEBREW	
				24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD	



FUNERAL DIRECTOR: IMPORTANT

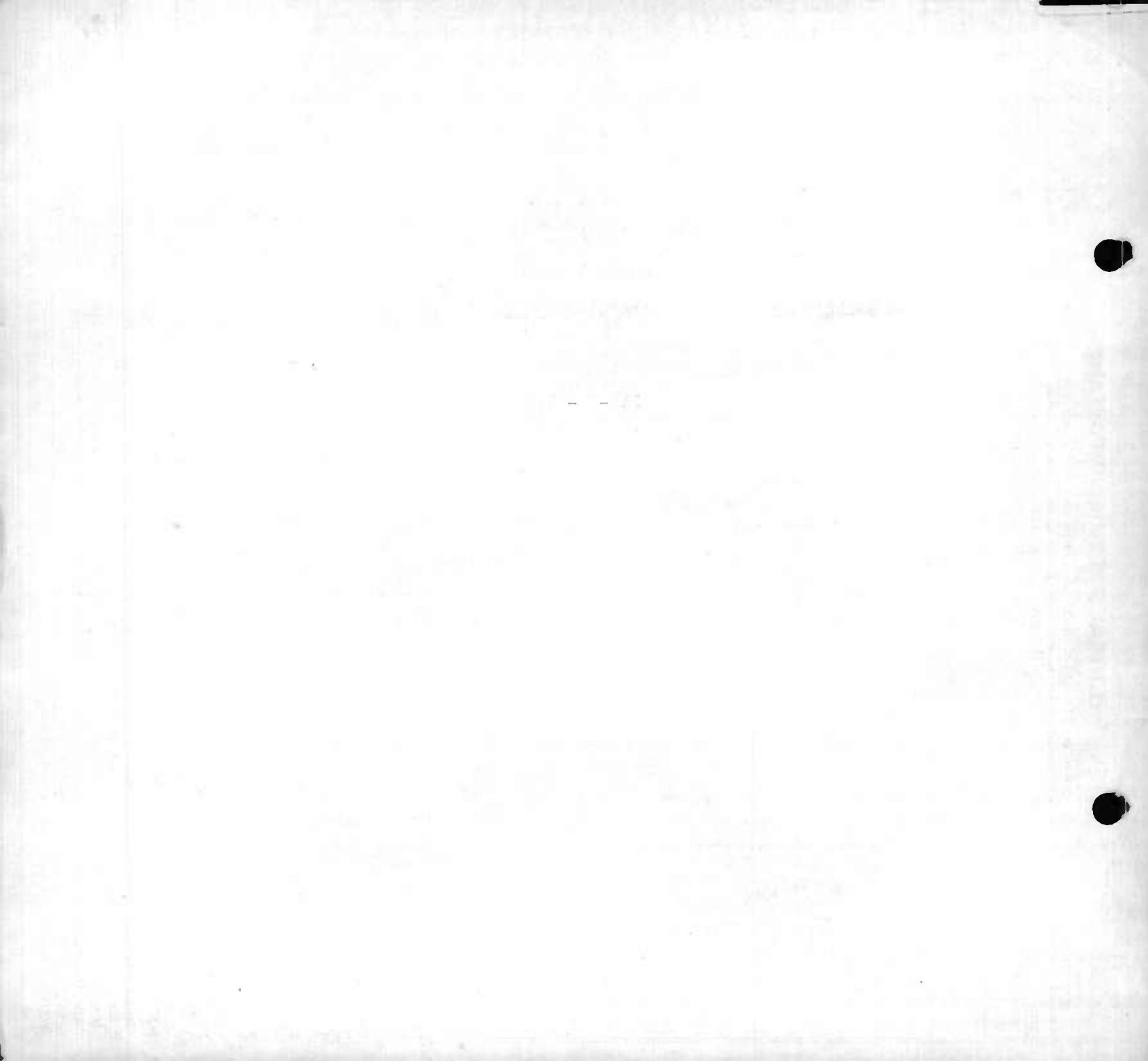
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8196				BALTIMORE CITY DEPARTMENT		Registered No. 65 8196	
1. NAME OF DECEASED (Type or Print) EVELYN SHERMAN (BURKOM)				2. DATE AND HOUR OF DEATH 8.5.65 1630 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-17 C. CITY OR TOWN (If outside city limits, write RURAL (and give township)) BALTIMORE D. STREET ADDRESS (If rural, give location) 2866 W GARRISON AVENUE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6/8/1912	9. AGE (In years last birthday) 53	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) LITHUANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BARRY BURKOM				14. MOTHER'S MAIDEN NAME MINNIE GOLDSTEIN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MR. LESTER SHERMAN 2866 W GARRISON AVE			
18. I 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) acute myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. atherosclerotic coronary heart disease				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 min. 10 yrs -	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? Yes or No No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from approx July 1958 to date of death 19 65 that (I) (we) last saw the deceased alive on approx July 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Frank W Davis Jr.				23B. DATE SIGNED 8.5.65			
23C. PHYSICIAN'S NAME (Type) Frank W Davis Jr.				23D. ADDRESS 118 Chase St Baltimore 2 Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/6/65		24C. NAME OF CEMETERY OR CREMATORY BETH ISRAEL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8197	
BIRTH NO. 65 8197		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Hilda LaRue Rowe		2. DATE AND HOUR OF DEATH 8-6-65 1 33⁰ a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-06		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hosp. for Women of Maryland		D. STREET ADDRESS (If rural, give location) 3239 S. Clifton Ave		16	
5. SEX F	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 9-1-1894	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bookbinder		10B. KIND OF BUSINESS OR INDUSTRY Baltimore Library		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Charles Rowe		14. MOTHER'S MAIDEN NAME Friggell, Ida	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-09-9775		17. INFORMANT Patient's chart.	
18. 15-7 X H-260 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Carcinoma of the Pancreas DUE TO Multiple Chondromatosis (B) Pancreatic Carcinoma DUE TO Anaemia (C) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 4 months?	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 1st 19 65 to Aug 6th 19 65 , that (I) (we) last saw the deceased alive on Aug 5th 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. P. Flynn		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-6-65	
23C. PHYSICIAN'S NAME (Type) FLYNN, JAMES P. G.		M.D.		23D. ADDRESS	
24A. BURIAL CREMATION/REMOVAL (Specify) Burial	24B. DATE 8/9/1965	24C. NAME OF CEMETERY or CREMATORY Greenmount Cemetery		24D. LOCATION (City, town, or county) (State) York, Penna.	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Wm. J. Johnson	
				ADDRESS Baltimore, Md. 21217	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death is shown: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8198		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8198	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GOODMAN THEODORE		2. DATE AND HOUR OF DEATH AUG 6/65 11.30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE NEW JERSEY B. COUNTY K-27		C. CITY OR TOWN (If outside city limits, write RURAL and give township) DEAL	
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 99 ROOSEVELT AVENUE	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH March 14, 1892	9. AGE (In years lost birthday) 73	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER-MANAGER		10B. KIND OF BUSINESS OR INDUSTRY FURNITURE		11. BIRTHPLACE (State or foreign country) Lithuania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME SOLOMON Goodman		14. MOTHER'S MAIDEN NAME JENNIE SOLOMON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) PULMONARY EMBOLISM		CAUSE OF DEATH (A) DUE TO PHELEBOTHROMBOSIS (B) DUE TO POST-OP. PROSTATECTOMY FOR CA. PROSTATE (C)		INTERVAL BETWEEN ONSET AND DEATH 5 hrs.	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION July 26/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA PROSTATE		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/21 19 65 to 8/6 19 65, that (I) (we) last saw the deceased alive on 8/6 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John Greisman		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/6/65	
23C. PHYSICIAN'S NAME (Type) JOHN GREISMAN		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE Aug. 8, 1965		24C. NAME OF CEMETERY or CREMATORY Brith Sholom	
24D. LOCATION (City, town, or county) (State) Fountain Hill, Penna.					
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Faller		25C. FUNERAL DIRECTOR G. J. Tichener & Son Balt. Md.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

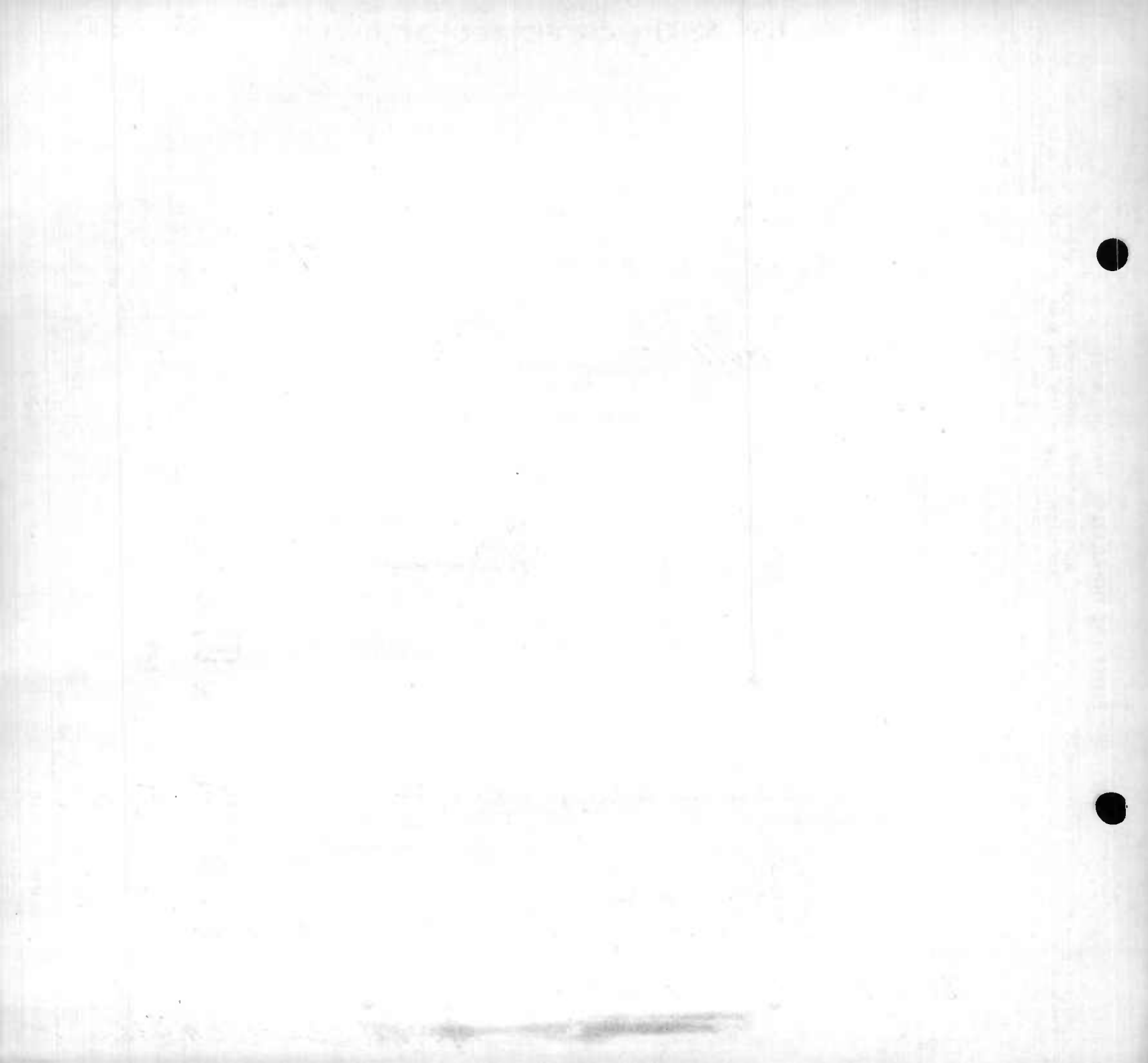
BIRTH NO. 65 8199				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 8199	
1. NAME OF DECEASED (Type or Print) William Waddy				2. DATE AND HOUR OF DEATH August 7, 1965 12:25 p.m.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital				4. USUAL RESIDENCE A. STATE Maryland B. COUNTY 17-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1132 Dorn Street					
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH April 3, 97	9. AGE (In years lost birthday) 68?	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) unknown md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME unknown William F. Waddy			14. MOTHER'S MAIDEN NAME unknown Sally Lee			17. INFORMANT ADDRESS unknown Elizabeth Brown Same			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 212-10-1891							
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiovascular Accident DUE TO (A) Cardiovascular Accident (B) Hypertensive Cardiovascular disease DUE TO (C) Diabetes Mellitus ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia by aspiration									
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from July 23, 1965 to August 7, 1965 , that (I) (we) last saw the deceased alive on August 7, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE [Signature] M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED August 7, 1965					
23C. PHYSICIAN'S NAME (Type) Andre Rigaud				23D. ADDRESS M.D. 1514 Division Street - Baltimore, Maryland					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/11/65		24C. NAME OF CEMETERY or CREMATORY Betho. Natl. Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS George A. Kila 1348 N. Calhoun St					

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

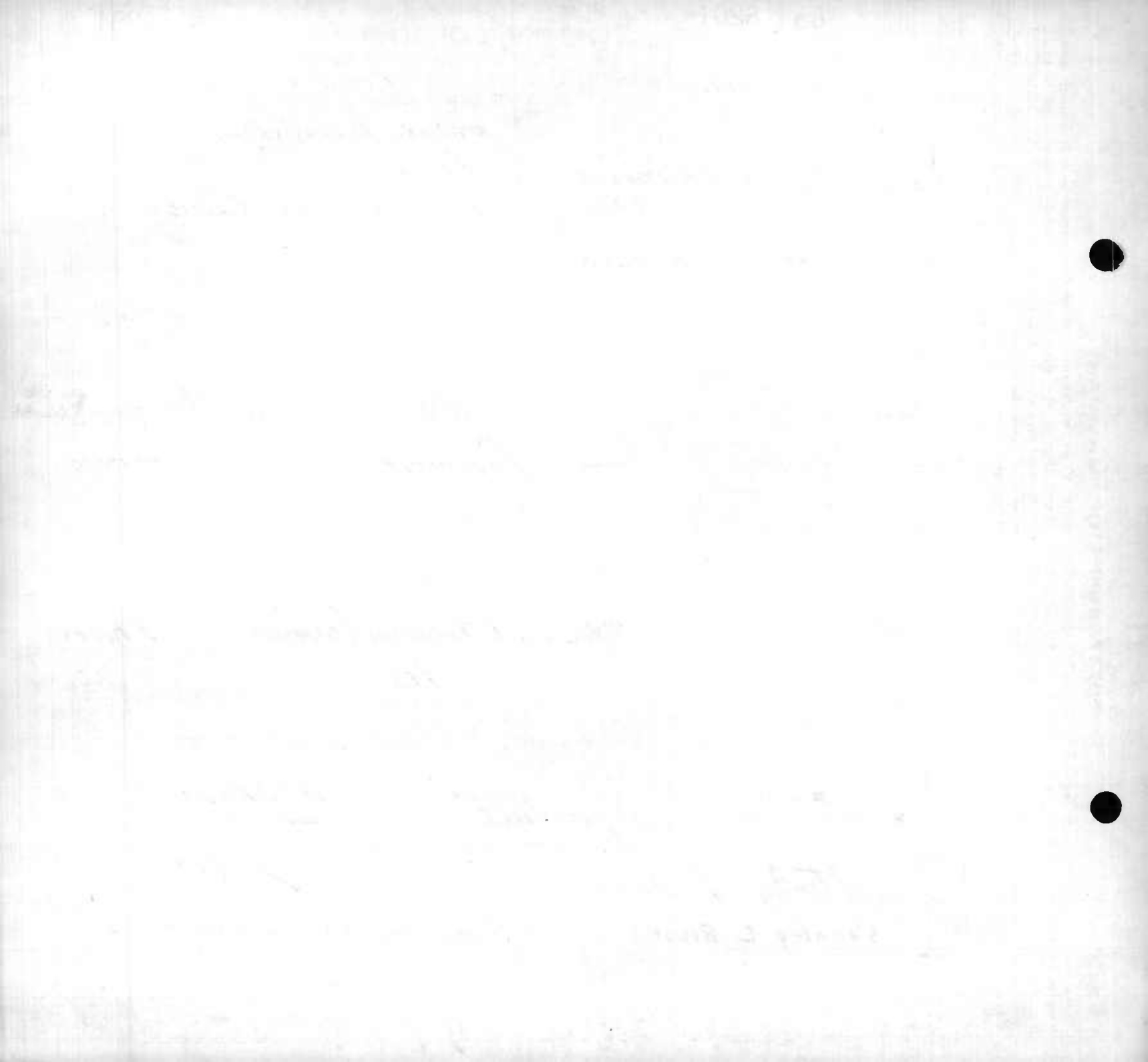
BIRTH NO. 65 8200		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8200	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Heidi Ruth</i>			2. DATE AND HOUR OF DEATH <i>8-5-65 10:30 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>George Washington Carver Nursing Home 607 Penna. Ave.</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>15-101</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1600 Vincent Ct.</i>		
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	B. DATE OF BIRTH <i>1-12-95</i>	9. AGE (In years lost birthday) <i>70</i>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Robert Hall</i>			14. MOTHER'S MAIDEN NAME <i>Rosa</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>George Washington Carver Nursing Home 607 Penna. Ave.</i> ADDRESS <i>Charle</i> (654)		
18. <i>443X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Cerebral aneurysm</i> DUE TO <i>Accident</i> (B) <i>Hypertensive arteriosclerosis</i> DUE TO <i>Cerebral aneurysm</i> (C) <i>Pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3/17/64</i> 19 to <i>8/5/65</i> 1965. that (I) (we) last saw the deceased alive on <i>8/5/65</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>J. N. Mac Murchy</i> M.D.				23B. DATE SIGNED <i>Aug 6/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>J. N. MAC MURCHY</i>		23D. ADDRESS <i>500 E Madison St.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/9/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Mem. Pk.</i>	
24D. LOCATION (City, town, or county) (State) <i>Arbutus, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 9 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <i>George H. Kline</i>			
25D. ADDRESS <i>1548 N. Calhoun St</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

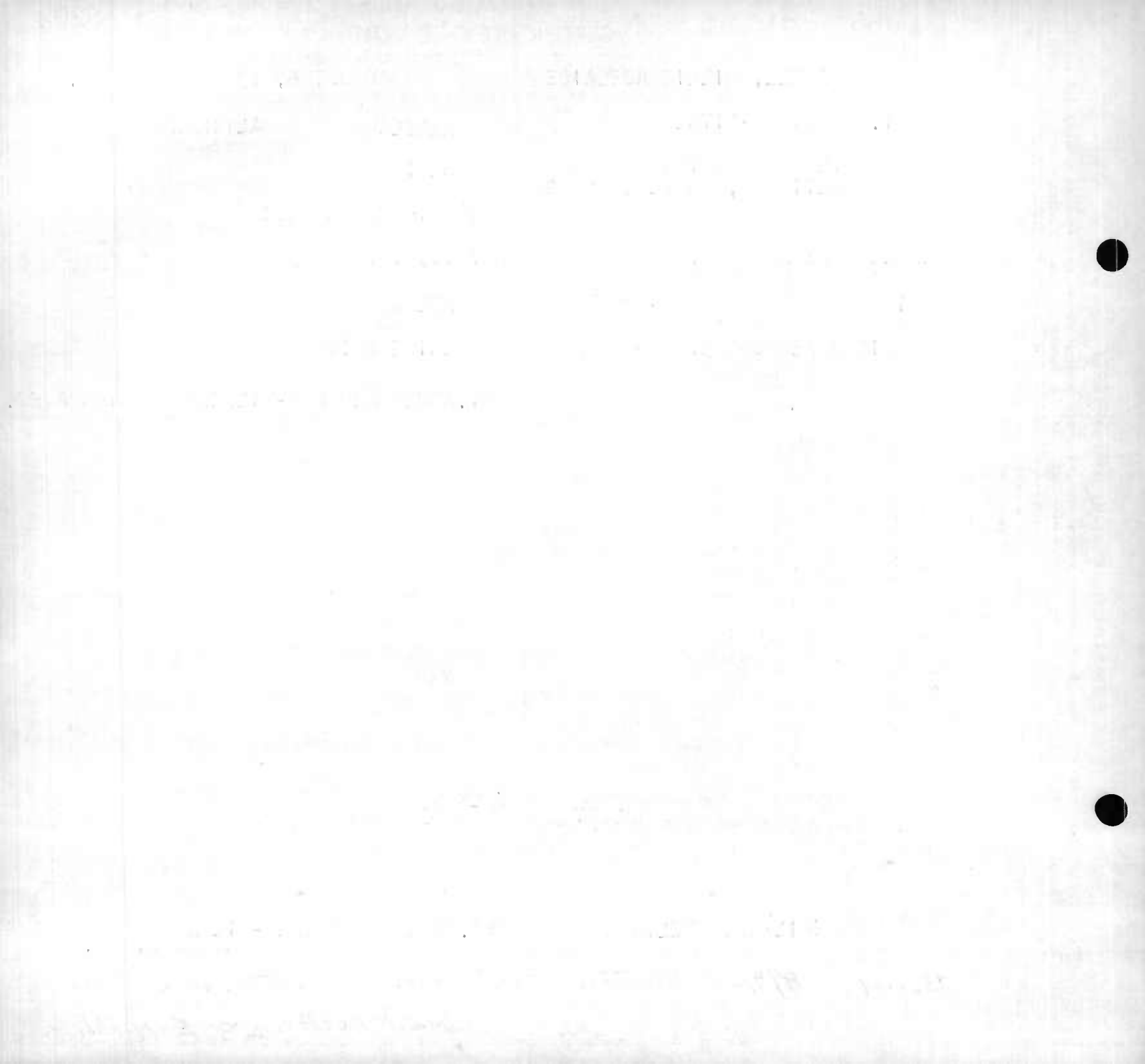
BIRTH NO. 65 8201		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8201	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>ANNA SHEPP.</u>			2. DATE AND HOUR OF DEATH <u>AUGUST 5 1965</u> <u>2⁰⁵</u> P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 Sinai Hospital of Baltimore (21215)</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>B. COUNTY</u> <u>MT. SINAI Nursing Home</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>Park Heights Ave. (21215) 4613-</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JULY 1893</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>SAMUEL</u>		
14. MOTHER'S MAIDEN NAME <u>HANNAH</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Nathan Shepp</u>		
18. <u>493X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>PNEUMONIA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>14 DAYS</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>MYOCARDIAL INFARCTION (SUSPECTED)</u>			8 hours.		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from <u>JULY 23 1965</u> to <u>AUGUST 5 1965</u> , that we (we) last saw the deceased alive on <u>AUGUST 5, 1965</u> and that my (our) opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.					
23A. SIGNATURE <u>Stanley L Blum</u>			23B. DATE SIGNED <u>8/5/65</u>		
23C. PHYSICIAN'S NAME (Type) <u>Stanley L Blum</u>			23D. ADDRESS M.D. <u>Sinai Hospital Baltimore Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/6/65</u>		24C. NAME of CEMETERY or CREMATORY <u>Rosedale</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 9 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fink</u>	
25C. FUNERAL DIRECTOR <u>Sylvan S Lewis</u>		25D. ADDRESS <u>3319 Olympia Ave</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

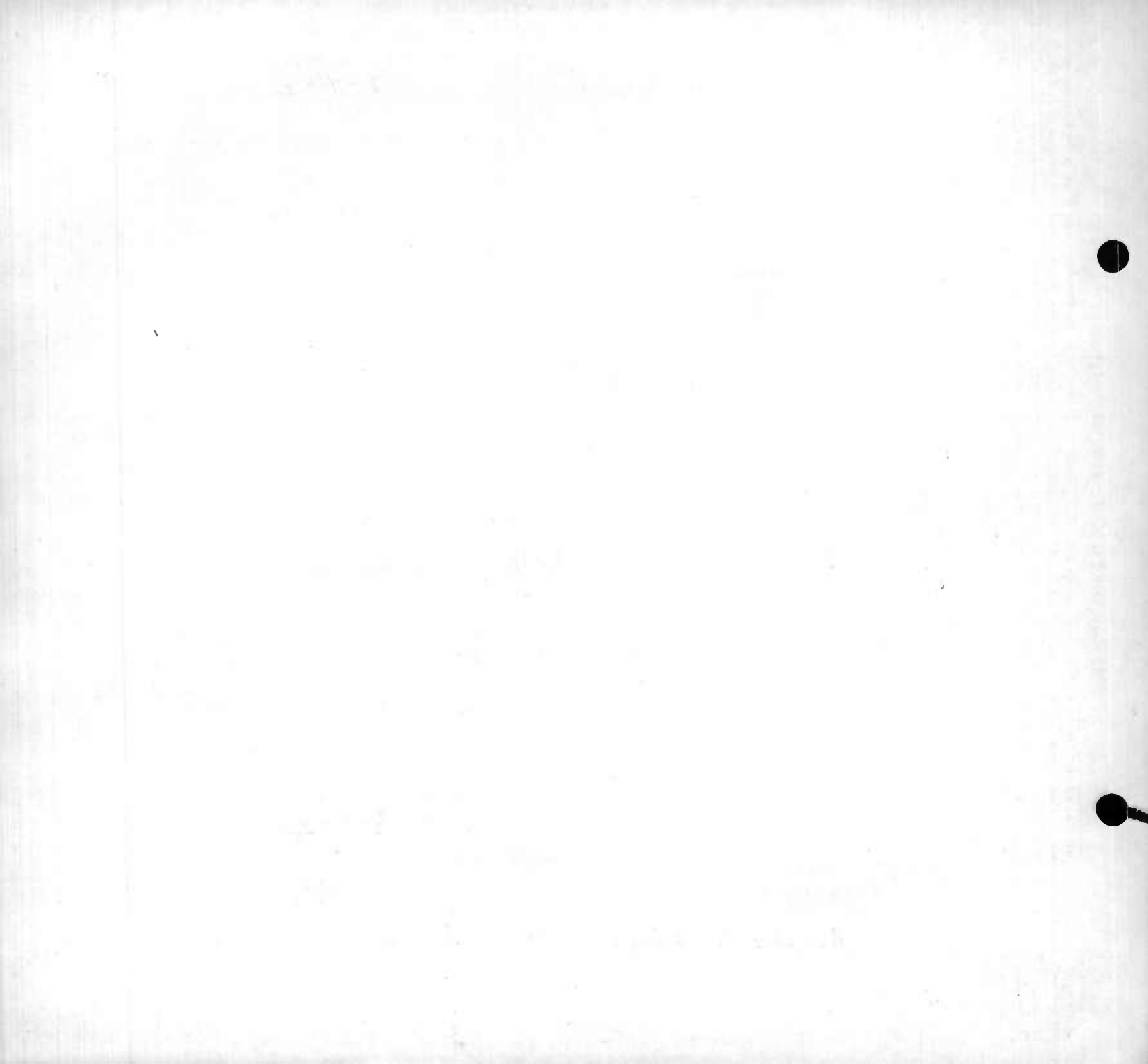
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 8202		CERTIFICATE OF DEATH		Registered No. 65 8202	
1. NAME OF DECEASED (Type or Print) TORSELL, MILLIE ADELAIDE				2. DATE AND HOUR OF DEATH AUGUST 6, 1965		4 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND ST. AGNES HOSPITAL <small>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</small> WILKENS & CATON AVENUES BALTIMORE, MARYLAND 21229				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 44 WINTERS AVENUE					
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH MAY 11, 1915	9. AGE (In years last birthday) 50	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAID			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JESSIE JAMES DORSEY			14. MOTHER'S MAIDEN NAME ADELAIDE SMITH						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT ST. AGNES RECORDS-WILKENS & CATON AVES.				
18. 465X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</small> Massive Pulmonary Emboli ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Massive Pulmonary Emboli DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JULY 25 19 65 to AUGUST 6 19 65 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on AUGUST 6 19 65 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (did not) view the body after death.									
23A. SIGNATURE Edilberto R. Beltran				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-6-65			
23C. PHYSICIAN'S NAME (Type) EDILBERTO BELTRAN				23D. ADDRESS ST. AGNES HOSPITAL - WILKENS & CATON AVE BALTIMORE, MD.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/9/65		24C. NAME OF CEMETERY or CREMATORY Western Star Cemetery Catonsville Md.		24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR W.M.G. MARCH 9 28 & Health Ave		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8203				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8203	
1. NAME OF DECEASED (Type or Print) CHARLES GIBSON				2. DATE AND HOUR OF DEATH 8-4-65 7:45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 The Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE MARYLAND B. COUNTY 5-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 14 N. CAROLINA ST			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SKP	B. DATE OF BIRTH 1-12-98	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Gibson				14. MOTHER'S MAIDEN NAME FERRIS SEARS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. 581.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) GRAM NEG SEPSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. FLORID ALCOHOLIC CIRRHOSIS ALCOHOLIC CIRRHOSIS				INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 1 1/2 MO. > 12 YRS.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 3-8-2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TRACHEOSTOMY		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JULY 1 1965 to AUG. 4 1965 , that (I) (we) last saw the deceased alive on AUG 4 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ashley T. Haase				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/4/65	
23C. PHYSICIAN'S NAME (Type) ASHLEY T. HAASE				23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/65		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel City	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Melvin C. March 928 E. North Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8204	
BIRTH NO. 65 8204		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) O'CONNOR JOHN P.		2. DATE AND HOUR OF DEATH Aug 5-65 12:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 12-84			
FULL NAME OF HOSPITAL OR INSTITUTION MERCY Hosp. INC		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 2223 St Paul St. Balb Md			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 8-27-1894	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME James T. O'Connor		14. MOTHER'S MAIDEN NAME Margaret Maubrey			
15. Was Deceased Ever in U. S. Armed Forces? (Yes or no or unknown) (If yes, give war or dates of service) Yes #1		16. SOCIAL SECURITY NO. 213-036155		17. INFORMANT Hospital records -	
18. 10 7X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Ca of the Pancreas		11 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
II		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 25 1965 to Aug 5 1965 , that (I) (we) last saw the deceased alive on Aug 5, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ruperto Manauka M.D.				23B. DATE SIGNED Aug 5, 1965	
23C. PHYSICIAN'S NAME (Type) RUPERTO MANAUKA M.D.				23D. ADDRESS MERCY HOSPITAL INC	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/65		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cn	
				24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor M.E.		25C. FUNERAL DIRECTOR Thomas J. Kenny Inc	
				ADDRESS Baltimore Md	

Rupert Manner
Rupert Manner

MERCY HOSPITAL INC
4-11

Aug 21 1964

James J. O'Connor

Margaret Manner

W. M. Manner

2-1-1964

MERCY HOSP. INC.

500 N. Pearl St. Phila. Pa.

1964

1964

1964

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 8205					CERTIFICATE OF DEATH					Registered No. 65 8205				
1. NAME OF DECEASED (Type or Print) <u>John E. Morse Sr.</u>					2. DATE AND HOUR OF DEATH <u>8-5-65 9:30 PM</u>					M.				
3. PLACE OF DEATH <u>BALTIMORE, MARYLAND</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u>									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bon Secours Hospital</u>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>CATONSVILLE</u>					53-00				
					D. STREET ADDRESS (If rural, give location) <u>23 DUNMORE RD.</u>									
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>W</u>		8. DATE OF BIRTH <u>4-17-1892</u>		9. AGE (In years last birthday) <u>72</u>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AGENT-RED.</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>INSURANCE</u>					11. BIRTHPLACE (State or foreign country) <u>MD.</u>				
12. CITIZEN OF WHAT COUNTRY?					13. FATHER'S NAME <u>Robert E. Morse</u>					14. MOTHER'S MAIDEN NAME <u>Catherine Dougherty</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>					16. SOCIAL SECURITY NO. <u>219-05488</u>					17. INFORMANT <u>John E. Morse Jr., 23 Dunmore Rd.</u>				
18. <u>420.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Intermittent heart disease</u> <u>Angioblastic heart failure</u>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <u>years (?)</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION <u>0</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?					22. I certify that (N) (this hospital) attended the deceased from <u>August 2, 1965</u> to <u>August 5, 1965</u> , that (N) (we) last saw the deceased alive on <u>August 5, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (N) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Alexander R. Lim</u>					M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <u>August 5, 1965</u>				
23C. PHYSICIAN'S NAME (Type) <u>Alexander R. Lim</u>					M.D. <u>Bon Secours Hospital</u>					23D. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>8-9-65</u>					24C. NAME of CEMETERY or CREMATORY <u>Catholic Cem.</u>				
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>					25A. DATE REC'D BY HEALTH DEPT. <u>AUG 9 1965</u>					25B. NAME OF REGISTRAR <u>John E. Morse Jr.</u>				
25C. FUNERAL DIRECTOR <u>Forbes Funeral Home - Catonsville, Md.</u>					ADDRESS									

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8206		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8206	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CATHY D. GOMER		2. DATE AND HOUR OF DEATH 8-6-65 14 ⁰⁰ M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2 S. MORLEY ST.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 20-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto 29 D. STREET ADDRESS (If rural, give location) 2 S. Morley St.			
5. SEX F	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH July 10, 1963	9. AGE (In years last birthday) 2	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Harvey W. Gomer		12. CITIZEN OF WHAT COUNTRY?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Family Address Same	
18. 204.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>Acute Leukemia</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 Months	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 19 65 to 6 August 1965, that (I) (we) last saw the deceased alive on 4 August 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lauriston L. Keown M.D.		23B. DATE SIGNED 7 Aug 65		23C. PHYSICIAN'S NAME (Type) Lauriston L. Keown M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-9-65		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cem	
24D. LOCATION (City, town, or county) Old Baltimore MD		24E. STATE 21217		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965	
25B. NAME OF REGISTRAR Robert E. Fawcett		25C. FUNERAL DIRECTOR 1938 Linden Ave 237 Catonsville		25D. ADDRESS	

Great Britain

1840

London

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65 8207

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 8207

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 8207

M-426

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) TRENT TOWERS A. Melchor

2. DATE AND HOUR PRONOUNCED DEAD August 6, 1965 7:38 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland B. COUNTY New York

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore New York City

D. STREET ADDRESS (If rural, give location) 1 Center Circle Unknown

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital

5. SEX male

6. RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married

8. DATE OF BIRTH July 17, 1937

9. AGE (In years last birthday) 28

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Manager - Howard Johnson

11. BIRTHPLACE (State or foreign country) N.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Hoarce Melchor

14. MOTHER'S MAIDEN NAME Mary Ann Talbert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Mrs. Sandra Woelper, 7807 Elmhurst Ave

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO Gunshot wound of head

(B) DUE TO

(C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home

21C. WHERE DID INJURY OCCUR? 1 Center Circle

21D. TIME OF INJURY (APPROX.) 8 6 65 Midnight

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Shot self

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 8-6-65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial

23B. DATE Aug. 9, 1965

23C. NAME OF CEMETERY or CREMATORY Moreland Mem Park

23D. LOCATION (City, town, or county) (State) Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT. AUG 9 1965

24B. NAME OF REGISTRAR Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR Leonard J. Ruck Inc 5305 Harford Rd.

24D. ADDRESS

VS 151-REV. 1/1/65

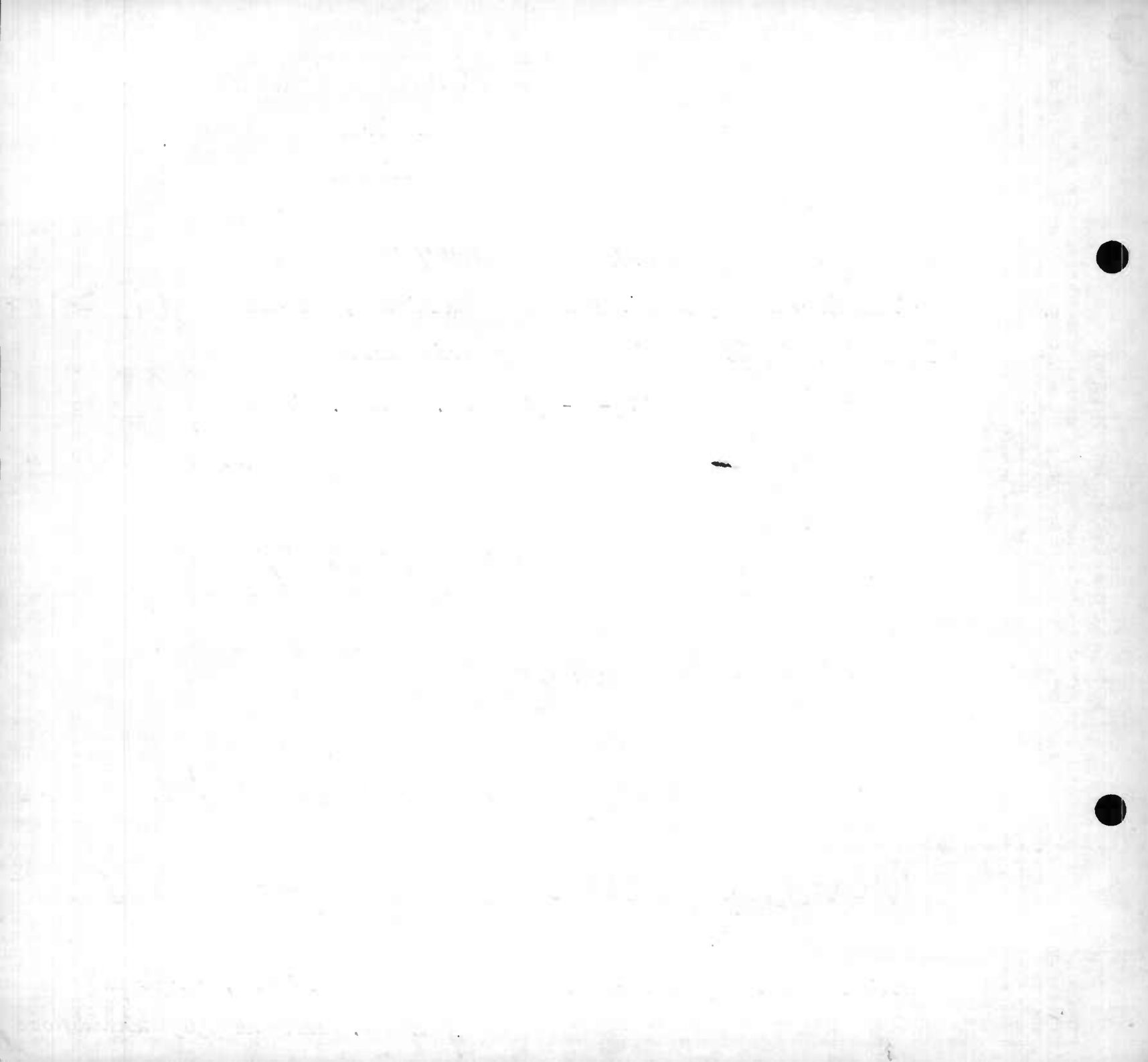
N 85 314 5000 7720

VALLEY FORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 65 8208		CERTIFICATE OF DEATH	
M.E. CASE NO.		Registered No. 65 8208	
1. NAME OF DECEASED (Type or Print) MICHAEL ZIEGLER		2. DATE AND HOUR OF DEATH 8-6-65 7 ⁰⁰ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL		A. STATE Maryland B. COUNTY 27-05	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN Baltimore D. STREET ADDRESS 7602 Bagley Avenue	
5. SEX M	6. RACE W	7. MARRIED , NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH NOV. 7 1902
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brewer		10B. KIND OF BUSINESS OR INDUSTRY Globe Brewery	9. AGE (In years lost birthday) 62
13. FATHER'S NAME Frederick Ziegler		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-01-9414	12. CITIZEN OF WHAT COUNTRY? M. S. A
17. INFORMANT Mrs. Anna A. Ziegler		ADDRESS same	
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Aspiration Vomitus		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ca lung			
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 12/29/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ca lung	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/28 1965 to 8/6 1965 that (I) (we) lost saw the deceased alive on 8/6 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Neville Perry		23B. DATE SIGNED 8/6/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/10/65	
24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Fink	
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc		ADDRESS 5305 Harford Road	



BIRTH NO.

65

8209

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65

8209

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARY ANN SORENSON (Sorensen)

2. DATE AND HOUR PRONOUNCED DEAD

August 6, 1965 1:45 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1 Center Circle

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Dec 30, 1916

9. AGE (in years
last birthday)

48

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Guest Home

10B. KIND OF BUSINESS OR INDUSTRY

Prop.

11. BIRTHPLACE (State or foreign country)

York, S.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William S. Talbert

14. MOTHER'S MAIDEN NAME

Carrie Howe

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

237-28-1700

17. INFORMANT

Mr. Raymond S. Sorensen

ADDRESS

same

18. E981X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of head
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

1 Center Circle

21D. TIME
OF INJURY
(APPROX.)

8

6

65

Midnight

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Shot

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-6-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Aug. 9, 1965

23C. NAME of CEMETERY or CREMATORY

Moreland Mem Park

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

AUG 9 1965

24B. NAME OF REGISTRAR

Robert E. Farley M.D.

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc 5305 Harford Rd.

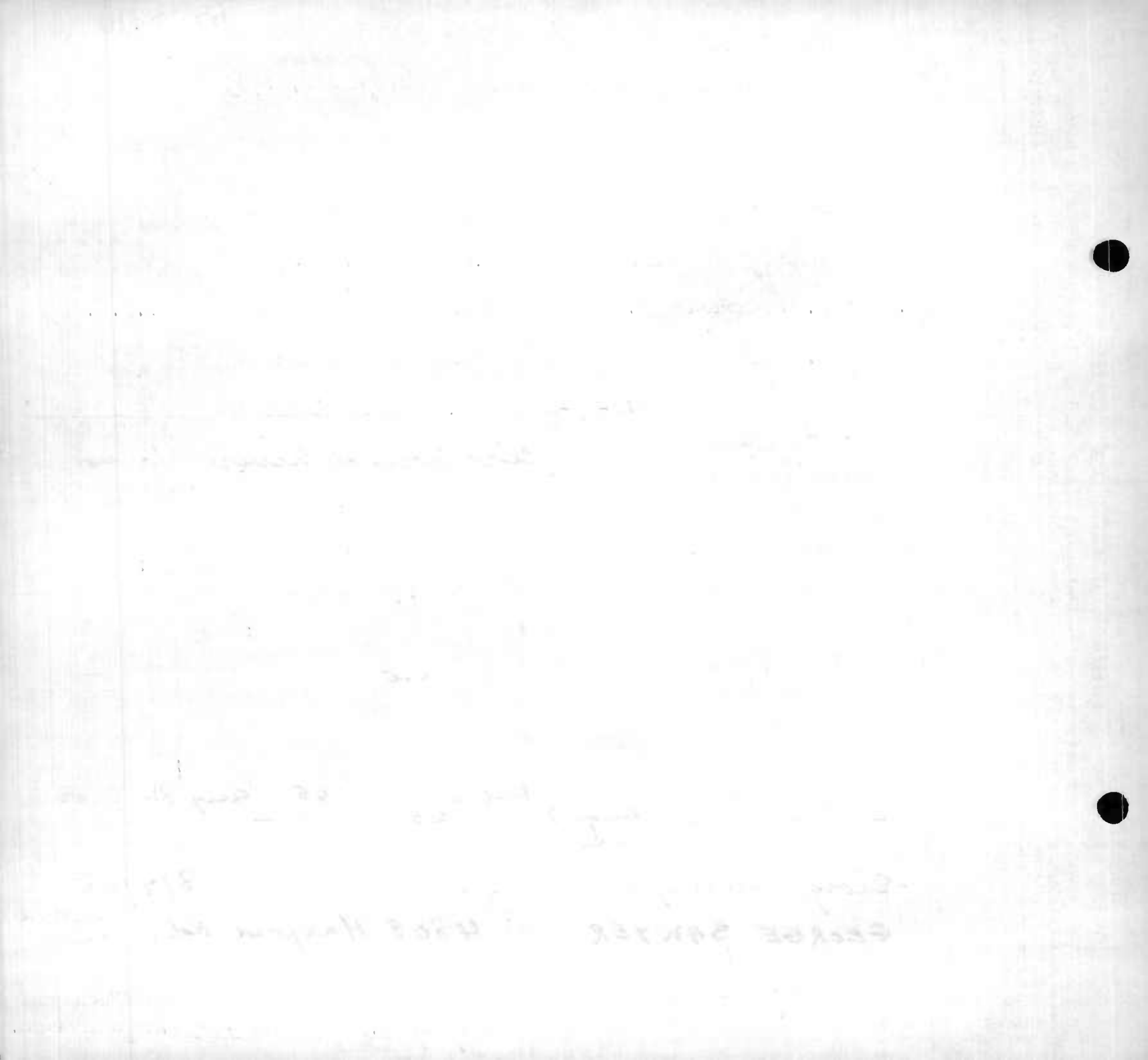
ADDRESS

VALLEY VIEW CO. INC.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

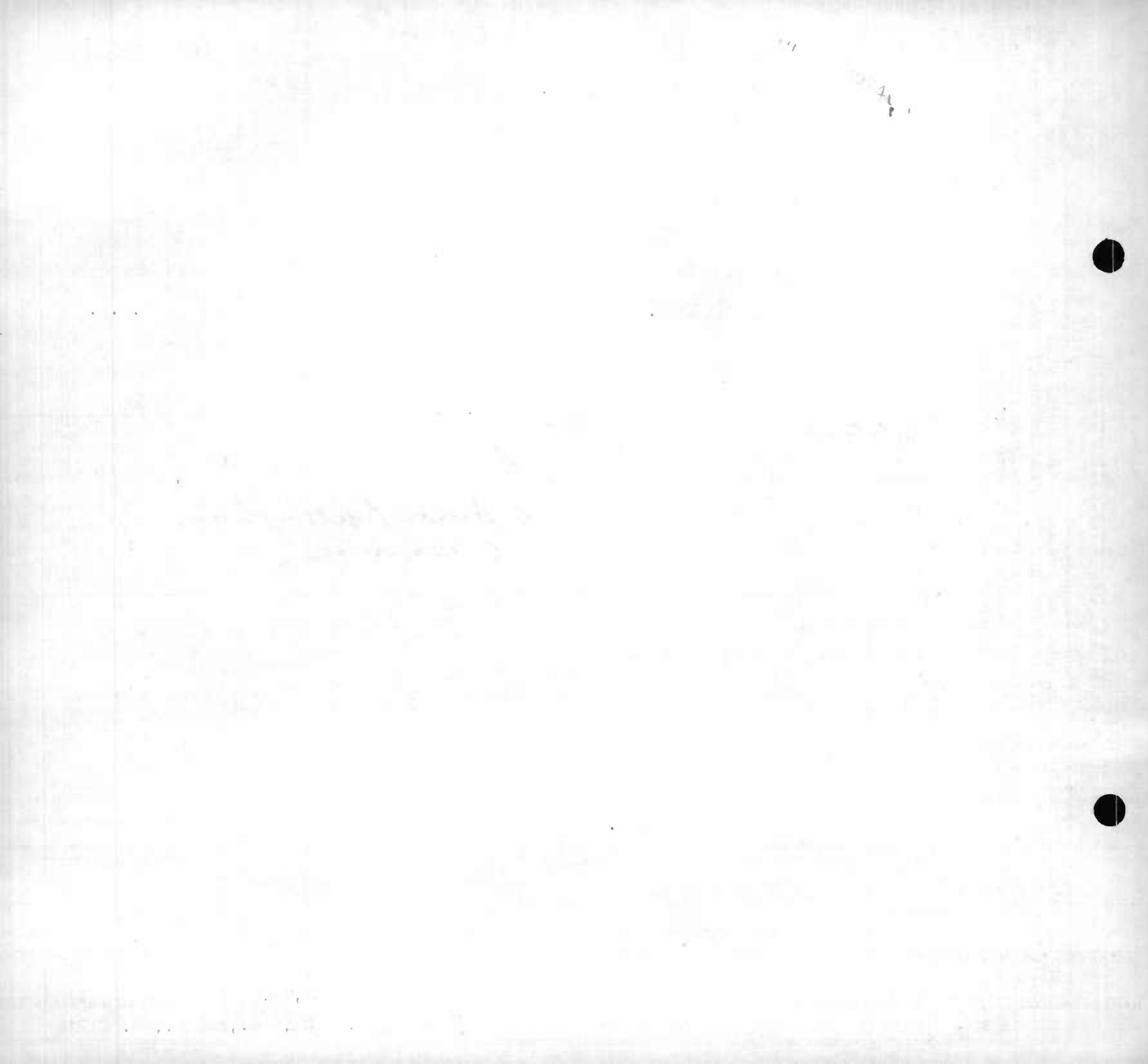
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8210	
BIRTH NO. 65 8210		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Charles Carmel Winkes		2. DATE AND HOUR OF DEATH August 8, 1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Maryland 8. COUNTY 27-03			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5222 Harford Road		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 5222 Harford road			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH July 3, 1901	9. AGE (In years lost birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. C & P. Telephone Co.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Anthony A. Winkes			14. MOTHER'S MAIDEN NAME Mary Ann Cookley		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-03-6823		17. INFORMANT Mrs. Stella Winkes	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Cirrhosis of liver (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 2 1965 to Aug 8 - 1965, that (I) (we) last saw the deceased alive on Aug 7 - 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (We) (did not) view the body after death.					
23A. SIGNATURE George Sawyer M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 8/9/65	
23C. PHYSICIAN'S NAME (Type) GEORGE SAWYER		23D. ADDRESS 4808 Harford Rd. Balto 14 Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/12/65	24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR Leonard J. Ryck Inc 5305 Harford Road.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		65 8211		65 8211	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		GROVES, EARL G.		2. DATE AND HOUR OF DEATH 8-7-65 4:45 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MD		B. COUNTY 27-05	
CHURCH HOME & HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
		D. STREET ADDRESS (If rural, give location)		3008 CHESLEY AVE	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 11-11-15	9. AGE (In years last birthday) 49	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
BETH STEEL		ENGR.		U.S.A.	
13. FATHER'S NAME GEORGE GROVES		14. MOTHER'S MAIDEN NAME — ELSIE ROSENTHAU		ADDRESS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-26-3811		17. INFORMANT MR. H. EDWARD ROSENTHAU	
				SAME	
18. 600,01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Acute Pulmonary 20 (B) DUE TO Acute Pyelonephritis (C) DUE TO Tuberculosis		INTERVAL BETWEEN ONSET AND DEATH 4 days YEARS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-30 1965 to 8-7 1965, that (I) (we) last saw the deceased alive on 8-7 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ephraim B. Barzaga		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-8-65	
23C. PHYSICIAN'S NAME (Type) EPHRAIM B. BARZAGA		23D. ADDRESS CHURCH HOME & HOSP. BALTO. 31, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 8/11/65	24C. NAME OF CEMETERY or CREMATORY TRINITY CEMETERY		24D. LOCATION (City, town, or county) (State) BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert S. Falk		25C. FUNERAL DIRECTOR LEONARD J. ARUCK, INC., BALTO., MD. 21214	



GENERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8212		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 85 8212	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) FRANCES R. KRAMER		2. DATE AND HOUR OF DEATH 8/6/1965 3:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALT. CITY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 5300	
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL		D. STREET ADDRESS (If rural, give location) 170 ELIZABETH AVE.			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 9/9/02	9. AGE (In years lost birthday) 62	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN WILSON		14. MOTHER'S MAIDEN NAME FANNY UNKNOWN Schpeder	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-8400		17. INFORMANT HOSPITAL CHART	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION 2mos		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH arteriosclerotic cardiovascular disease			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		MEDICAL CERTIFICATION			
19A. DATE OF OPERATION June 3, 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Heart		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1 1965 to August 6 1965 , that (I) (we) last saw the deceased alive on August 6 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Linden Struth		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8.6.65	
23C. PHYSICIAN'S NAME (Type) Linden Struth		M.D. Maryland Gen. Hospital		23D. ADDRESS Baltimore Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-10-65		24C. NAME of CEMETERY or CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc		ADDRESS 5305 Harford Rd.			

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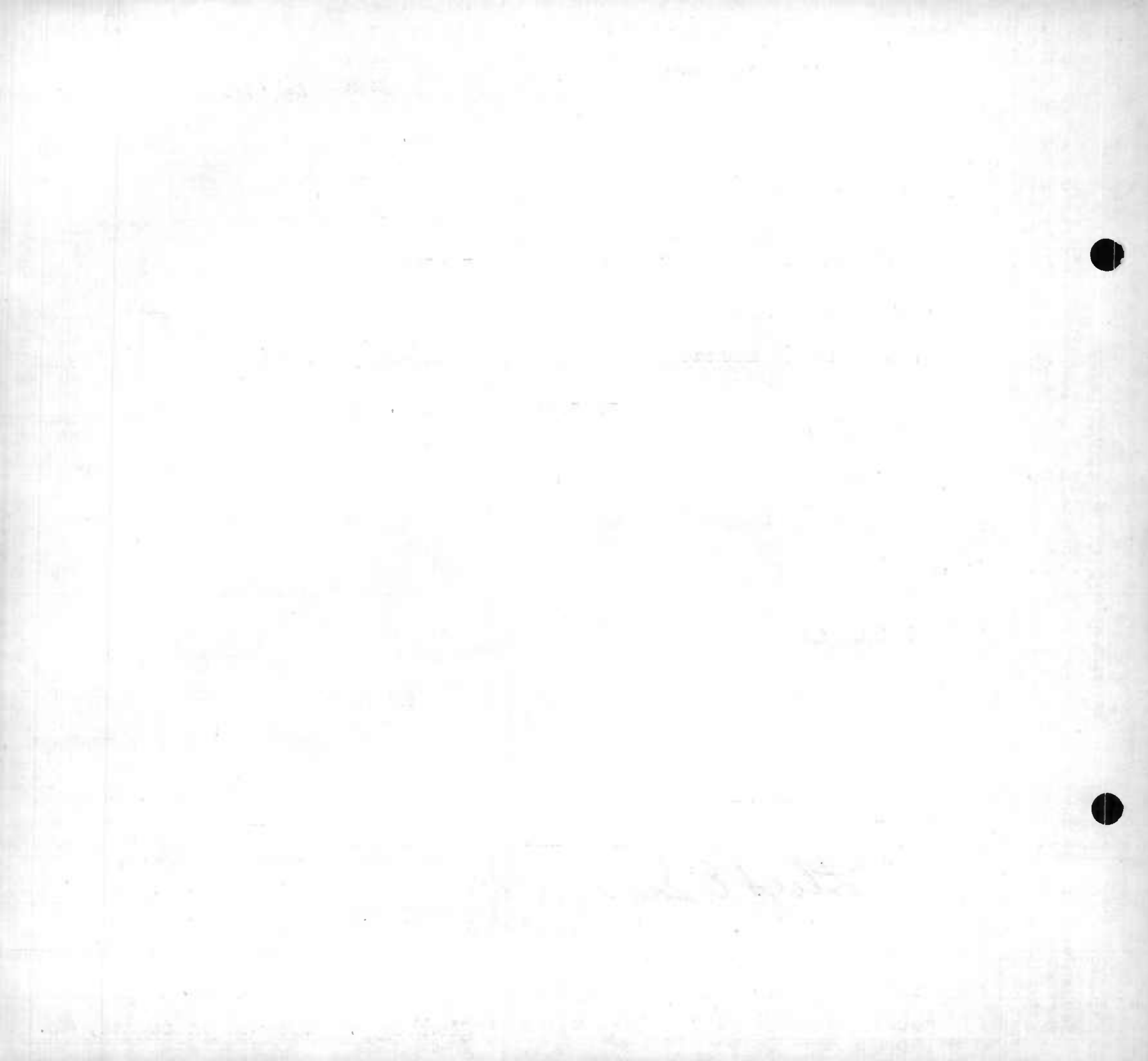
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FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 8213		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8213	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Lilla Ilda North			2. DATE AND HOUR OF DEATH August 7, 1965 1 8:30 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Gould Convalesarium			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 27-05		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 34		
			D. STREET ADDRESS (If rural, give location) 3125 Northway Drive		
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 2-21-1886	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Henry Morris Leonard		14. MOTHER'S MAIDEN NAME Ida Mae George	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-46-9885		17. INFORMANT Clyde M. North	
18. 422.11		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) Arteriosclerotic cardiovascular disease		10 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Hiatus hernia (large)		30 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from May 19 65 to August 7, 19 65 , that (I) (we) last saw the deceased alive on August 6, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Lloyd E. Saylor		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Aug. 9, 1965	
23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor		M.D. 23D. ADDRESS 3902 Greenmount Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 8/10/65		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md.		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

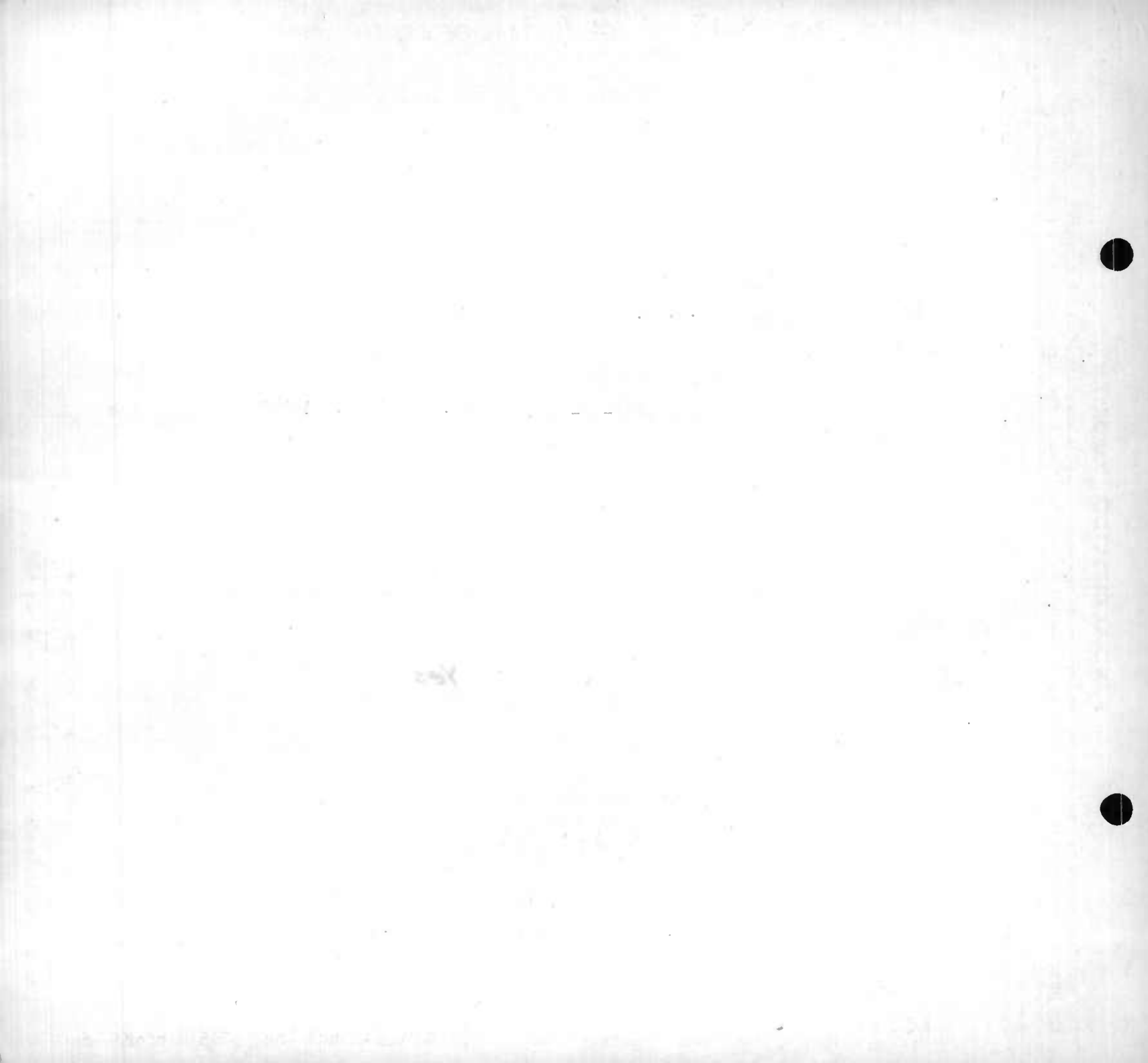
BIRTH NO. 65 8214		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65-8214	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) LORENZO Bandiera			2. DATE AND HOUR OF DEATH 8-8-65 6:40 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Little Sisters of the Poor 1200 VALLEY ST. BALTIMORE MD 21202			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) B. COUNTY MD. C. CITY OR TOWN (If outside city limits, write RURAL and give township) 1200 VALLEY ST. D. STREET ADDRESS (If rural, give location) BALTIMORE N		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED (specify) Widowed	8. DATE OF BIRTH 1-29-1879	9. AGE (In years lost birthday) 86	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? ITALY
13. FATHER'S NAME SABATO BANDIERA			14. MOTHER'S MAIDEN NAME MARIANNA CACCIATA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 246-12-5682	17. INFORMANT ADDRESS Little Sisters of The Poor		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cerebral accident			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized arterio sclerosis, Parkinson disease					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1964 to Aug 8 19 65 , that (I) (we) last saw the deceased alive on Aug 8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stanley Ankudof M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 8.9.65	
23C. PHYSICIAN'S NAME (Type) STANLEY ANKUDAS		23D. ADDRESS M.D. 1802 W BALTIMORE ST.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/11/65	24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc 5305 Harford Rd.	

vs. 153 signed by funeral director. 8/16/65 C. Bowens

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

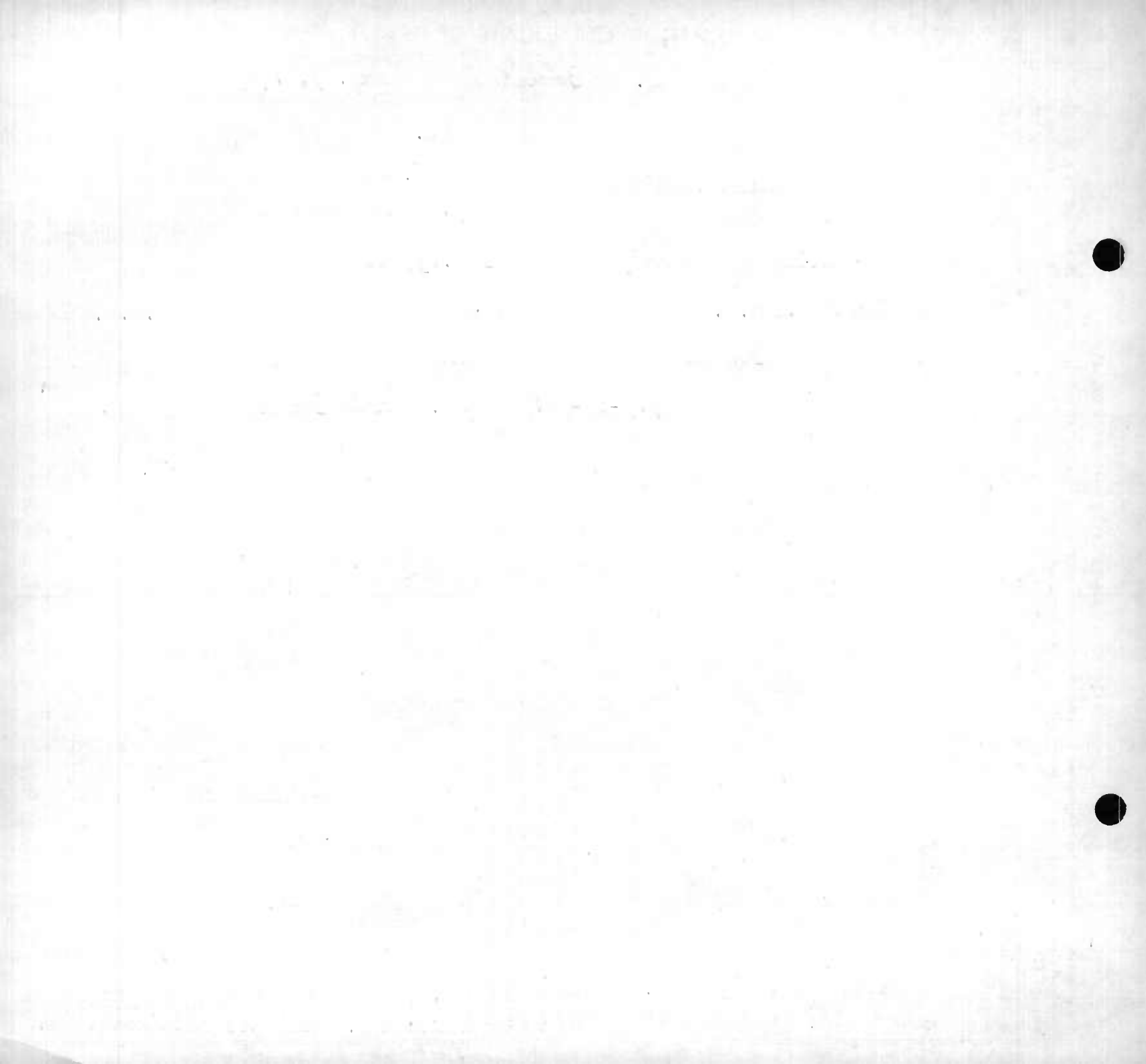
BIRTH NO. 65 8215		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8215	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ELMER NICKEL		2. DATE AND HOUR OF DEATH August 8, 1965 8:54 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	
8. DATE OF BIRTH 12/2/00		9. AGE (In years last birthday) 64		10. If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10B. KIND OF BUSINESS OR INDUSTRY B.T.Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES		13. FATHER'S NAME Julius Nickel		14. MOTHER'S MAIDEN NAME Emma Lysher	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 210-13-0198		17. INFORMANT Mrs. Bessie M. Nickel	
18. 163 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Edema		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) Ca, lung & metastasis		INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION 7/20/65		20. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca, lung & metastasis		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 7 19 65 to August 8 19 65 , that (I) (we) last saw the deceased alive on August 8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Desiderio L. Hebron, Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 8, 1965	
23C. PHYSICIAN'S NAME (Type) DESIDERIO L. HEBRON, JR.		23D. ADDRESS LUTHERAN HOSPITAL OF MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/12/65		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965			
25B. NAME OF FUNERAL DIRECTOR Robert J. Buck		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Buck Inc 5305 Harford Rd			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

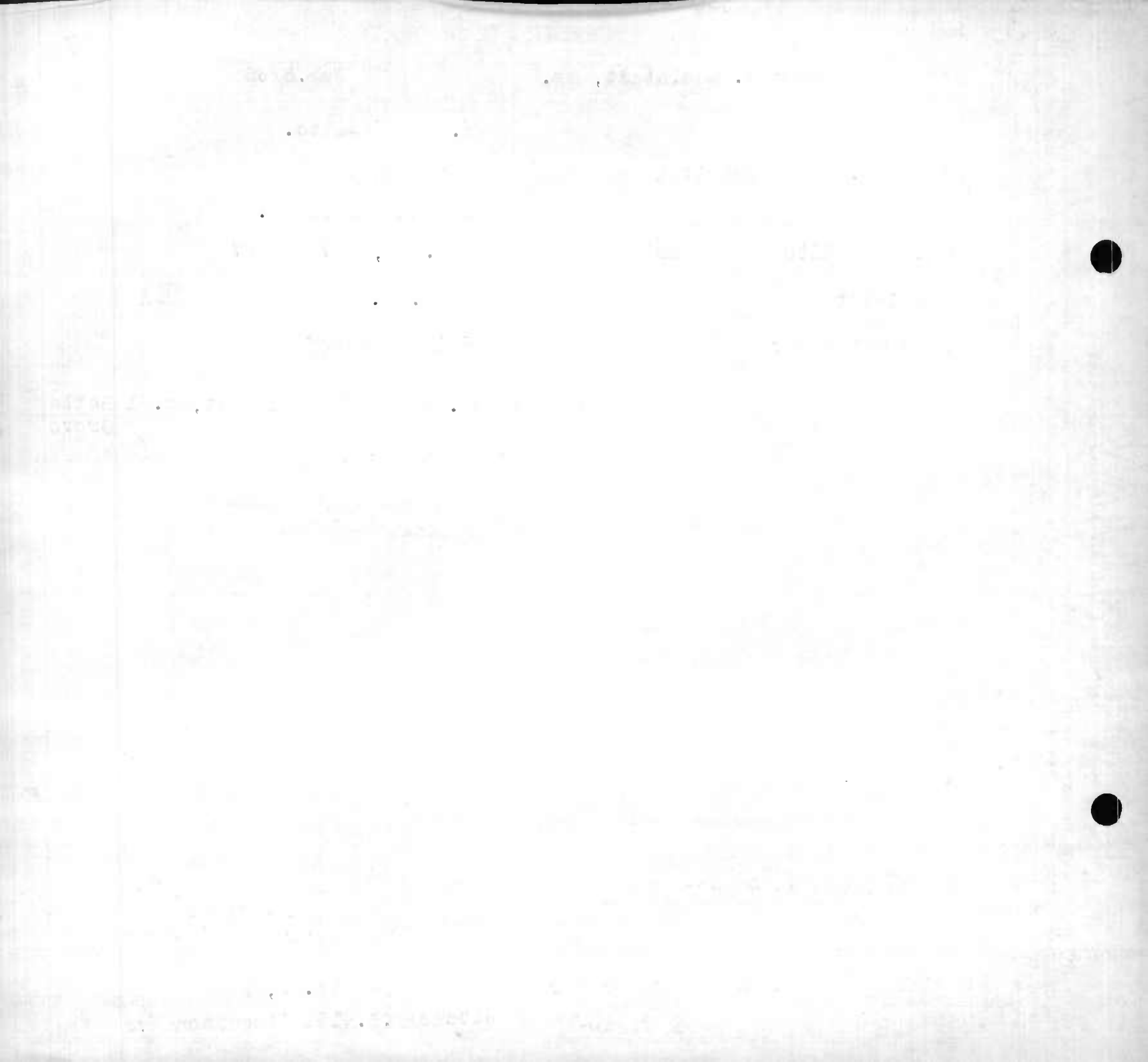
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8216	
BIRTH NO. 65 8216		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Wilmer O. Fowler		2. DATE AND HOUR OF DEATH Aug. 7, 1965 6⁰⁰ P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 27-05		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 7125 Harford Road		
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH Feb. 18, 1887	9. AGE (In years lost birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Penna R.R.			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Sam Fowler			14. MOTHER'S MAIDEN NAME Mary Ohmet		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 717-07-7015		17. INFORMANT Mrs. Virgie Fowler ADDRESS same
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO Stokes Adams Syndrome Sudden (B) DUE TO Coronary Artery Disease 6+ yrs (C) Arteriosclerotic Cardiovascular disease 10 yrs None		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from April 1960 to Present 1965 , that (I) (we) last saw the deceased alive on Feb 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/9/65
23C. PHYSICIAN'S NAME (Type) F. T. KASIK JR			23D. ADDRESS 9005 Harford Rd.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/11/65	24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

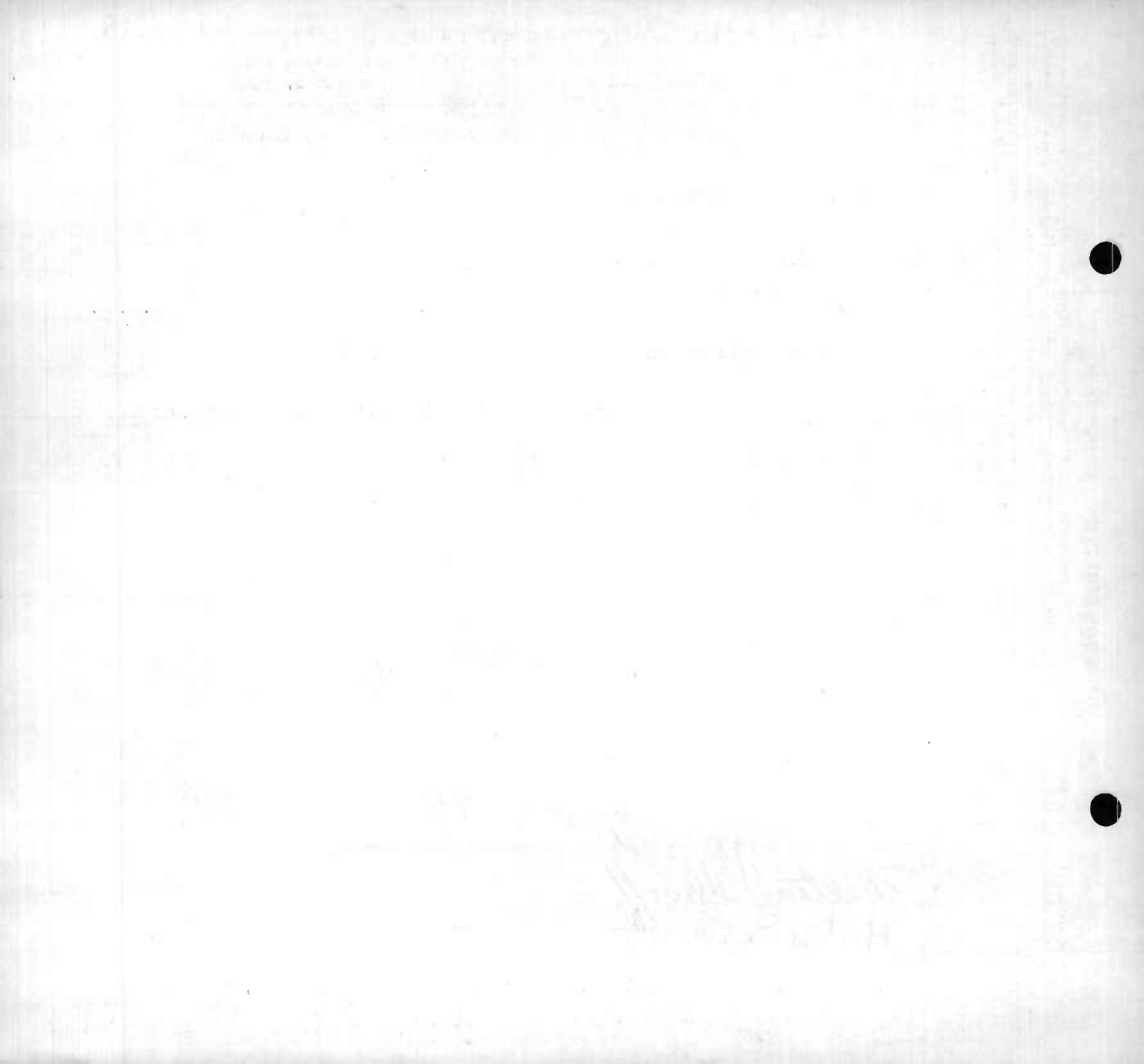
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		65 8217		65 8217	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		John W. Mahlstedt, Sr.		2. DATE AND HOUR OF DEATH Aug. 5/65	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
St. Agnes Hospital		Md. Balto.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Catonsville			
		D. STREET ADDRESS (If rural, give location)			
		51 Belle Grove Rd.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.
Male	White	Married	Sept. 11, 1907	57	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Machinist		Coast Guard	Balto. Md.		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John Mahlstedt			Matilda Scharf		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
		705 07 9258	Mrs. Elizabeth Mahlstedt, Sr. 51 Belle Rd		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II		(A) DUE TO		Sudden	
ANTECEDENT CAUSES		(B) DUE TO		7 Months	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 7-1 19 57 to 8-2 19 65, that (I) (we) last saw the deceased alive on 8-5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Elmer W. Johnson				8/9/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				M.D. 3432 S. Frederick Ave. Baltimore Md 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8/9/65		Loudon Park	
				Balto. 29, Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 9 1965		A. E. Falk		Witke, F. D. 4101 Edmondson Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

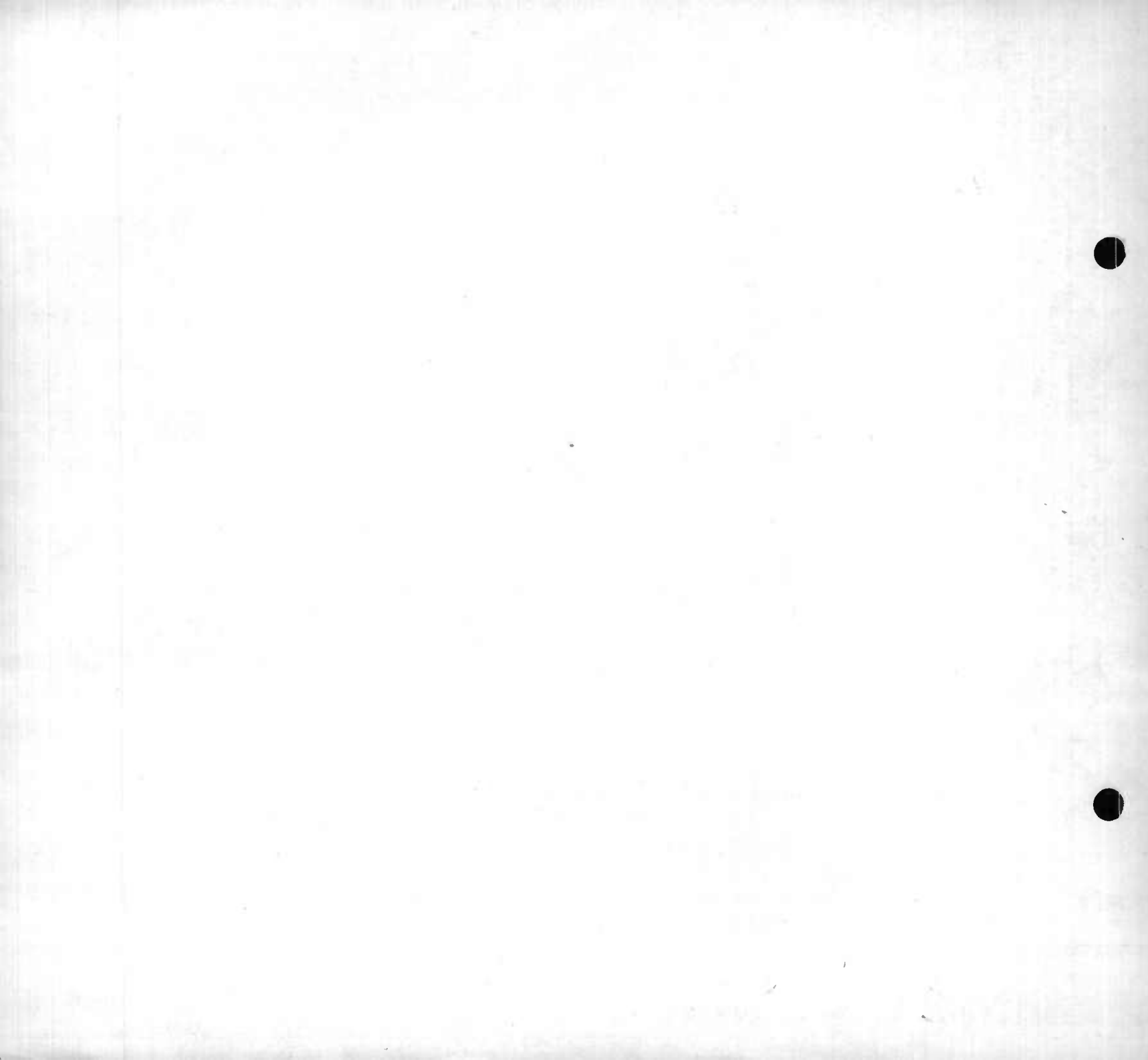
BIRTH NO. 65 8218				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8218	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) John Clifton Gettier				2. DATE AND HOUR OF DEATH August 6, 1965			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 5325 Wesley Avenue				A. STATE Maryland B. COUNTY Baltimore			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 5325 Wesley Avenue			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 9/27/1878	9. AGE (In years last birthday) 86	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engraver			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Frederick Gettier				14. MOTHER'S MAIDEN NAME Ida Fisher			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-01-3345		17. INFORMANT ADDRESS Virginia Pyles 5325 Wesley Avenue			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 430.01				CAUSE OF DEATH (A) Congestive Cardiac failure DUE TO (B) Arteriosclerosis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 wk	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/2/65 19 to 8/6/65 19, that (I) (we) last saw the deceased alive on 8/1/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Milton Schewoff				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/6/65	
23C. PHYSICIAN'S NAME (Type) Milton Schewoff				23D. ADDRESS 6400 Windsor Mill Rd			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/9/65		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Ellsworth Armacost		ADDRESS 4600 Liberty Heights	



FUNERAL DIRECTOR: IMPORTANT

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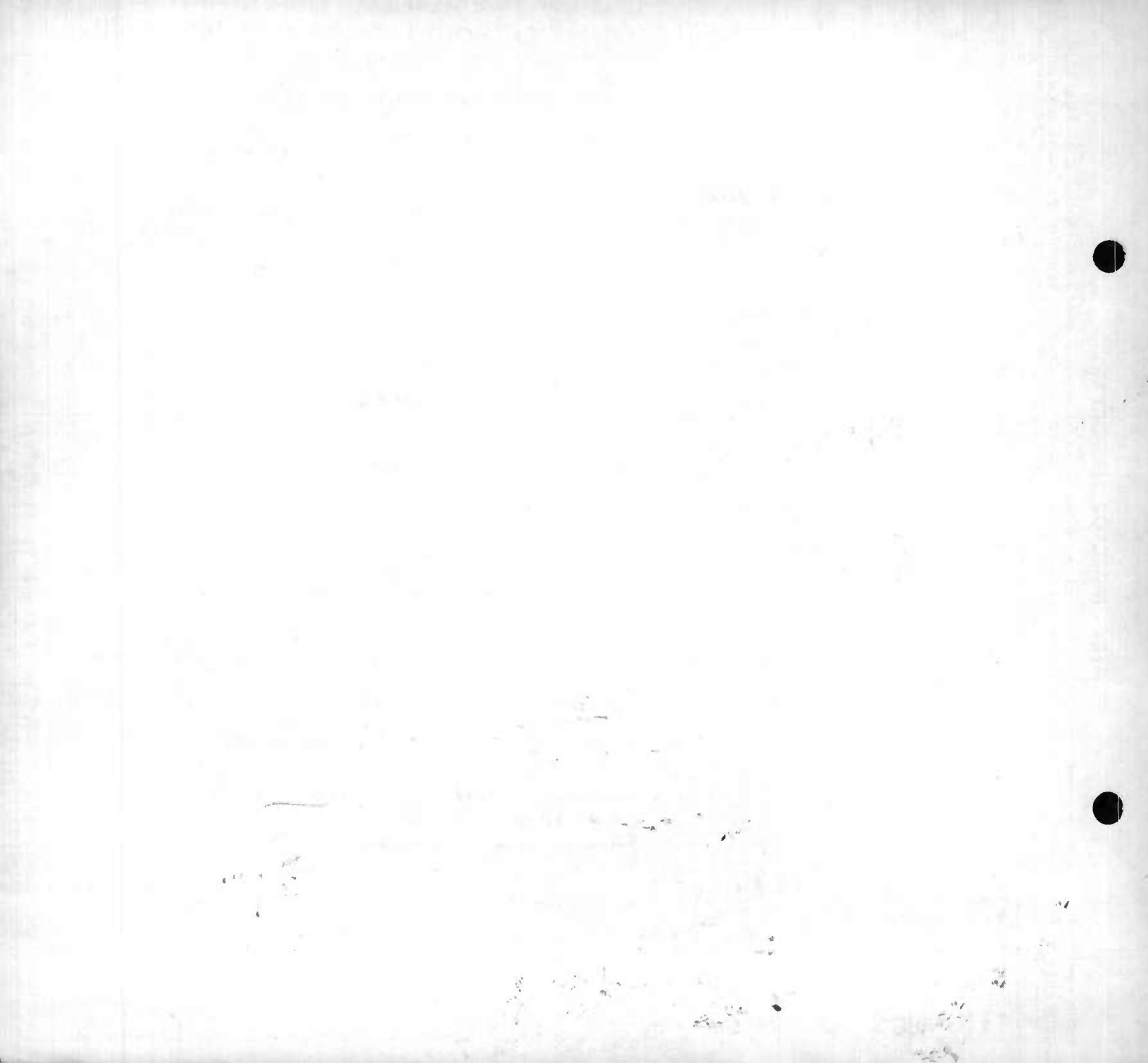
BIRTH NO. 6517597 65 8219		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8219	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) BABY GIRL NEALE "A"			7-28-65 6:20 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSPITAL			A. STATE MARYLAND B. COUNTY 13-04		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 2429 REGISTER TOWN RD		
5. SEX F	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 7-19-65	9. AGE (In years last birthday) 0	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEW BORN		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ROBERT NEALE			14. MOTHER'S MAIDEN NAME ELAINE JACKSON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) IMMATURITY			INTERVAL BETWEEN ONSET AND DEATH 9 DAYS		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-19-65 to 7-28-65 , that (I) (we) last saw the deceased alive on 7-28-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joyce L. Chen			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-28-65
23C. PHYSICIAN'S NAME (Type) JOYCE L. CHEN			23D. ADDRESS ANATOMY BOARD OF MARYLAND JOHNS HOPKINS MEDICAL SCHOOL		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE AUG 9 1965	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

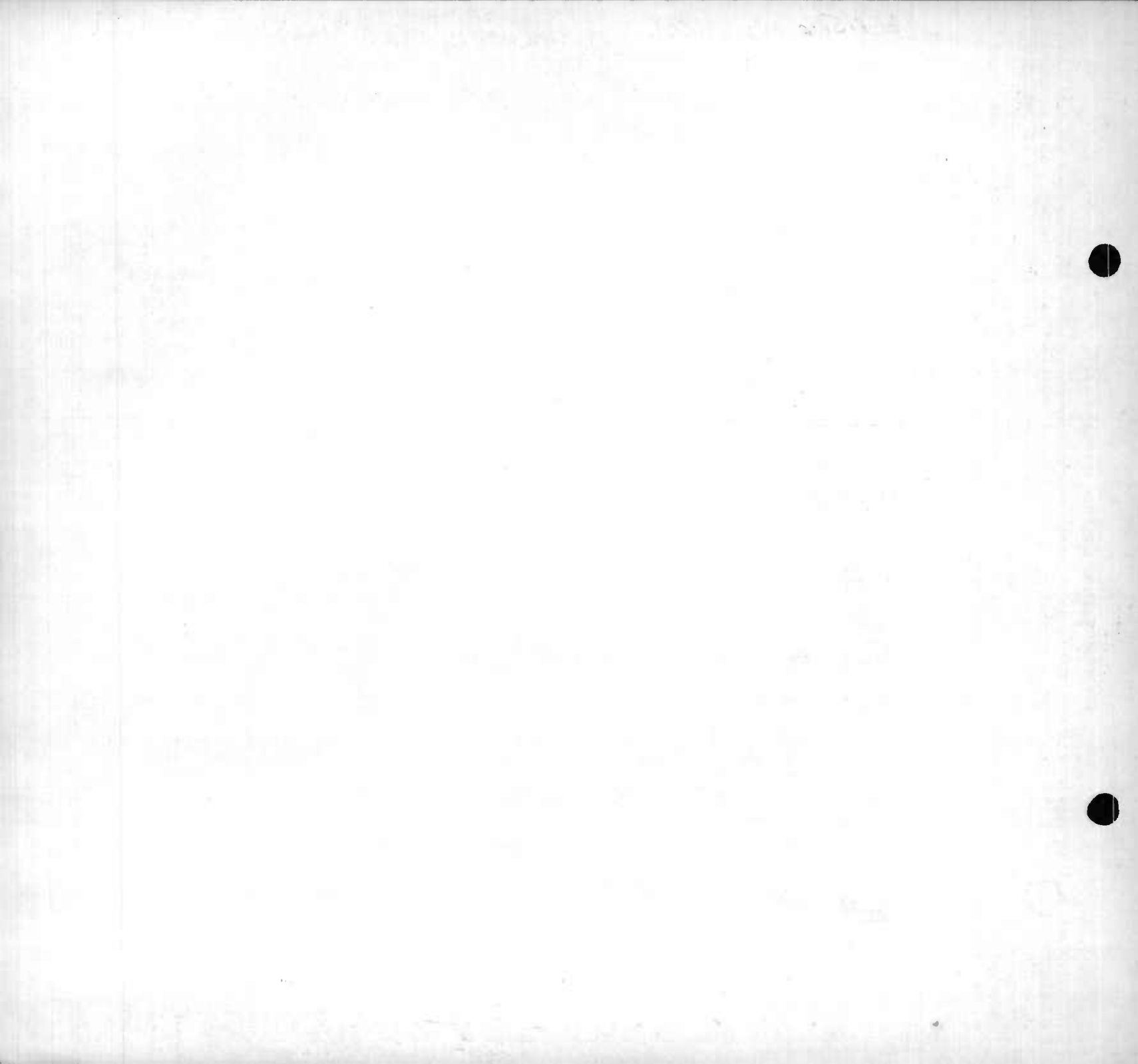
BIRTH NO. 65-17598 65 8220		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8220	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) NEALE GIRL B		2. DATE AND HOUR OF DEATH 7-21-65 10:30 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 13-04 D. STREET ADDRESS (If rural, give location) 2429 Reisterstown Road			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) -	8. DATE OF BIRTH 7-20-65	9. AGE (In years last birthday) 1	If Under 1 Yr. Months: 1 Days: 12 If Under 24 Hrs. Hours: 12 Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) newborn		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert Neale		14. MOTHER'S NAME Jackson, Elaine	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother ADDRESS Same	
18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) I maturity DUE TO (B) DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH 1 day 12 hours	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 7-20-1965 to 7-21-1965 , that we (we) last saw the deceased alive on 7-21-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		23A. SIGNATURE E. C. CRUZ M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> 23B. DATE SIGNED 7-22-65	
23C. PHYSICIAN'S NAME (Type) E. C. CRUZ		23D. ADDRESS ANATOMY BOARD OF MARYLAND		24A. BURIAL CREMATION, REMOVAL (Specify) AUG 9 1965	
24B. DATE AUG 9 1965		24C. NAME OF CEMETERY OR CREMATORY JOHNS HOPKINS MEDICAL SCHOOL		24D. LOCATION (City, town, or county) (State) MORTUARY SERVICE - BCHD	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

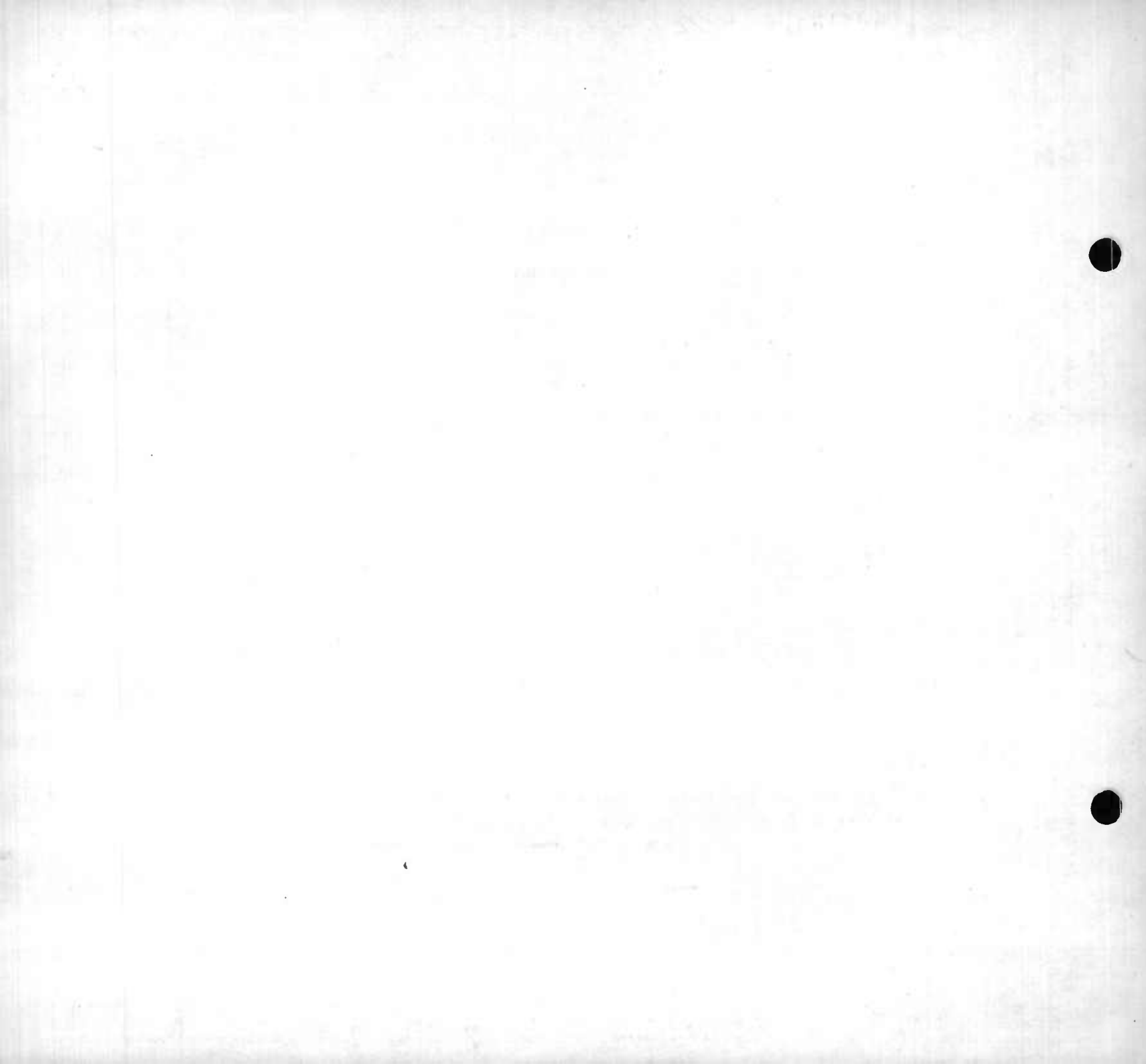
BIRTH NO. <u>65-7586 65 8221</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 8221</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Lintner, Baby Girl "A"</u>		2. DATE AND HOUR OF DEATH <u>July 21, 1965</u> <u>6:20</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai Hospital of Baltimore, Inc.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
5. SEX <u>Female</u>		6. RACE <u>Cauc.</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>never married</u>	
8. DATE OF BIRTH <u>7/19/65</u>		9. AGE (In years last birthday) <u>2</u>		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Heinrich Lintner</u>		14. MOTHER'S MAIDEN NAME <u>Pottervauer, Ingeborg</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>6</u>		17. INFORMANT ADDRESS	
18. <u>773.5</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) <u>Respiratory distress syndrome</u> DUE TO (B) <u>Prematurity</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>40 hrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 19, 1965</u> to <u>July 21, 1965</u> , that (I) (we) last saw the deceased alive on <u>July 21, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jere P. Smith</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7/21/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Jere P. Smith</u>		23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u> <u>JOHNS HOPKINS MEDICAL SCHOOL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>AUG 9 1965</u>		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL</u>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 9 1965</u>		25B. NAME OF REGISTRAR <u>John E. Tamm</u>	
25C. FUNERAL DIRECTOR ADDRESS <u>MORTUARY SERVICE - BCHD</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>65-19271 65</u> <u>8222</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65</u> <u>8222</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>BABY BOY WOOLEY</u>		2. DATE AND HOUR OF DEATH <u>8-3-65</u> <u>6:15A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>28-03</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>2845 Forest Glen Rd.</u>			
5. SEX <u>M</u>	6. RACE <u>Negro</u>	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>8-2-65</u>	9. AGE (in years last birthday) <u>16</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Pernie Wooley</u>		14. MOTHER'S MAIDEN NAME <u>Mercedes Davis</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS
18. <u>776X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>Immaturity</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from <u>8-2</u> 19 <u>65</u> to <u>8-3</u> 19 <u>65</u> , that we (we) last saw the deceased alive on <u>8-3</u> 19 <u>65</u> and that Int (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) not view the body after death.					
23A. SIGNATURE <u>Joyce L. Chen</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8-3-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOYCE L. CHEN</u>		23D. ADDRESS <u>Sinai Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>AUG 9 1965</u>		24B. DATE		24C. NAME OF CEMETERY OR CREMATOR <u>JOHNS HOPKINS MEDICAL SCHOOL</u>	
24D. LOCATION <u>MORTUARY SERVICE - BCHD</u>		24E. CITY, TOWN, or county		(State)	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 9 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		25C. FUNERAL DIRECTOR <u>JOHNS HOPKINS MEDICAL SCHOOL</u>	
25D. ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		65 8223		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8223-2742	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) LATTA, ALENE			
2. DATE AND HOUR OF DEATH 8-2-65 1:30 a.m.				3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Havn				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2023 Ridgehill Ave			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 7-1-31	9. AGE (In years last birthday) 34 yr.	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David McAllister				14. MOTHER'S MAIDEN NAME Carrie Graham			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Samuel Latta ADDRESS 2023 Ridgehill Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 5-87.01 + E 900 Bronchopneumonia				CAUSE OF DEATH Cardiac arrest		INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Fracture of left leg				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) Yes		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2023 Ridgehill Ave			
21D. TIME OF INJURY (APPROX.) 6:10 65 1:30		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell down steps		E 900	
22. I certify that (I) (this hospital) attended the deceased from 10 p.m. 7-31-1965 to 1:45 a.m. 8-2-1965 , that (I) (we) last saw the deceased alive on before death and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE F. K. ABBOUSY				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-2-65	
23C. PHYSICIAN'S NAME (Type) F. K. ABBOUSY				23D. ADDRESS Lutheran Havn			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-7-65		24C. NAME of CEMETERY or CREMATORY Carver Mem. Park		24D. LOCATION (City, town, or county) (State) Laurel, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert S. Phillips		25C. FUNERAL DIRECTOR Attingham S. Phillips		ADDRESS 1727 Monroe Street	

Handwritten notes and diagrams. Includes a large bracketed section on the right and several horizontal lines with arrows pointing to the right.

Vertical text on the left margin, possibly a page number or date.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8224				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8224	
1. NAME OF DECEASED (Type or Print) <u>George Matthews</u>				2. DATE AND HOUR OF DEATH <u>7:45 8/4/65</u> <u>7:45 A</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Howard</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore Ellicott City</u> D. STREET ADDRESS (If rural, give location) <u>2102 Church Avenue #27</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Separated</u>		8. DATE OF BIRTH <u>5/10/21</u>	9. AGE (In years last birthday) <u>44</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>porter</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Carl Matthew.</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Thomas.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>217-12-8748</u>		17. INFORMANT <u>Marie Matthews</u>		ADDRESS <u>2102 Church Avenue</u>	
18. <u>203X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osleria, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>multiple myeloma</u>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <u>Q</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Congestive Heart Failure, Anuria</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>we</u> (this hospital) attended the deceased from <u>7/17/1965</u> to <u>8/4/1965</u> , that <u>we</u> last saw the deceased alive on <u>8/4/1965</u> and that in <u>no</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>no</u> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>E. Ann Robinson</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/4/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>E. Ann Robinson</u>				23D. ADDRESS M.D. <u>University Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/9/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 9 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>William S. Phillips</u>		ADDRESS <u>1727 N. Monmouth</u>	

264970714

200 WYB

April 8/9/12 Baltimore, Md.

1

65 8225

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. *61-37750*MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. *65 8225*

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JEROME GOODMAN

2. DATE AND HOUR PRONOUNCED DEAD

8/6/65 8:40 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1911 Perlmann Court

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Nov 21, 1961

9. AGE (In years
last birthday)

3

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balt. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Johnnie Lee Goodman

14. MOTHER'S MAIDEN NAME

Lillian Gladys

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

Johnnie Lee Goodman

ADDRESS

18. E 812.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Cranio-cerebral injury

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A).....
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Perlmann Ct. near North Ave.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8 6 65 8:25 p.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

run over by wheel of truck

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/7/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Aug 9, 1965

23C. NAME of CEMETERY or CREMATORY

Baldwin Hill Cem

23D. LOCATION

(City, town, or county)

5501 Fidelity Ave

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 9

1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

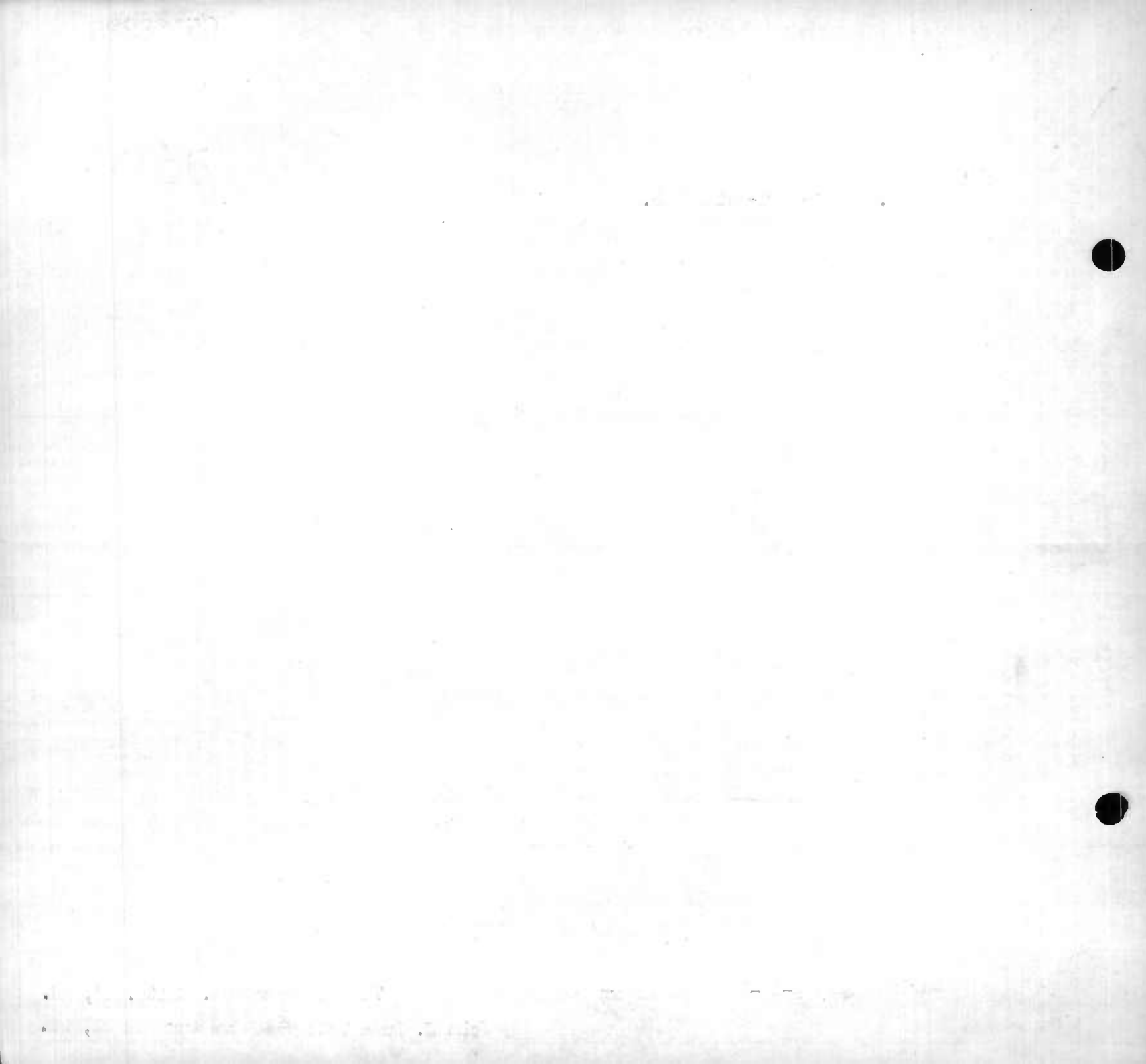
Milton E. Elickson 1129 N. Kentway

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

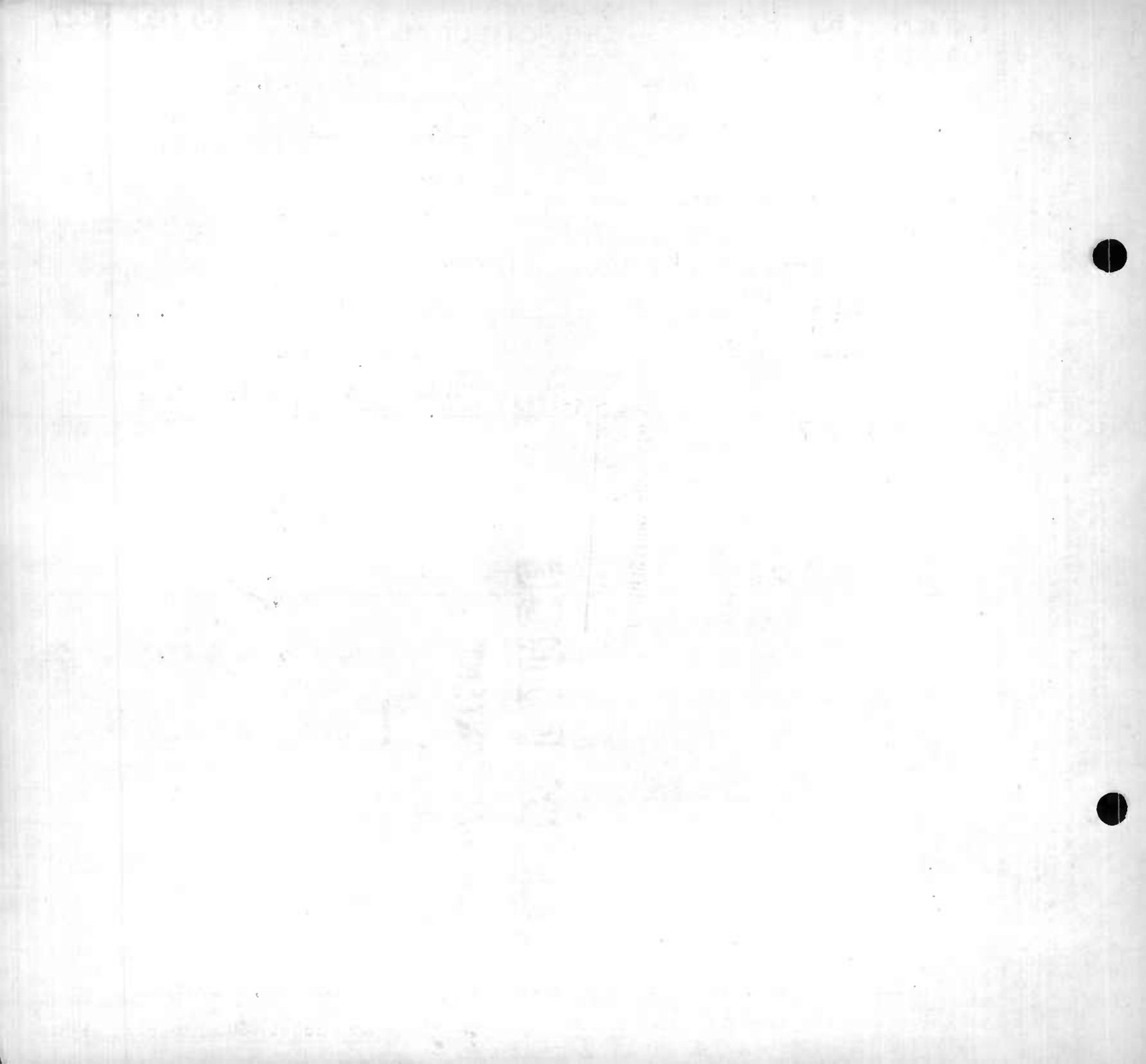
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 8226		CERTIFICATE OF DEATH				Registered No. 65 8226			
M.E. CASE NO.		1. NAME OF DECEASED ELEANOR ANNA PEDRICK				2. DATE AND HOUR OF DEATH AUG 7 1965 11 30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				5. AGE (In years last birthday)			
FULL NAME OF HOSPITAL OR INSTITUTION 604 S. Newkirk Street Balto.		(If not in hospital or institution, give street address or location)				A. STATE MARYLAND			
						B. COUNTY BALTIMORE			
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 2601			
						D. STREET ADDRESS (If rural, give location) 604 S. NEWKIRK ST.			
6. SEX FEMALE		7. RACE WHITE		8. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		9. DATE OF BIRTH OCT 21, 1910		10. AGE (In years last birthday) 54	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		12. KIND OF BUSINESS OR INDUSTRY		13. BIRTHPLACE (State or foreign country) PENNSYLVANIA		14. CITIZEN OF WHAT COUNTRY? USA		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. FATHER'S NAME VINCENT CELIO		17. MOTHER'S MAIDEN NAME MARY DIGUILLO		18. SOCIAL SECURITY NO. 817-26-6691		19. INFORMANT HUSBAND		20. ADDRESS 604 S. NEWKIRK ST.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) METASTATIC CARCINOMA DUE TO (B) CARCINOMA BREAST DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH 3 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from JUNE 1965 to AUG. 7 1965, that (I) (we) lost saw the deceased alive on AUG. 7 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Frank G. Kuehn		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Aug 7 1965			
23C. PHYSICIAN'S NAME (Type) FRANK G. KUEHN		23D. ADDRESS 721 MED ARTS BLDG BALTO 1 MD		23E. FUNERAL DIRECTOR John J. Duda		23F. ADDRESS 7922 Wise Ave Dundalk 22, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-11-1965		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) 7225 Eastern Ave. Balto. 24, Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR John J. Duda		25D. ADDRESS 7922 Wise Ave Dundalk 22, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

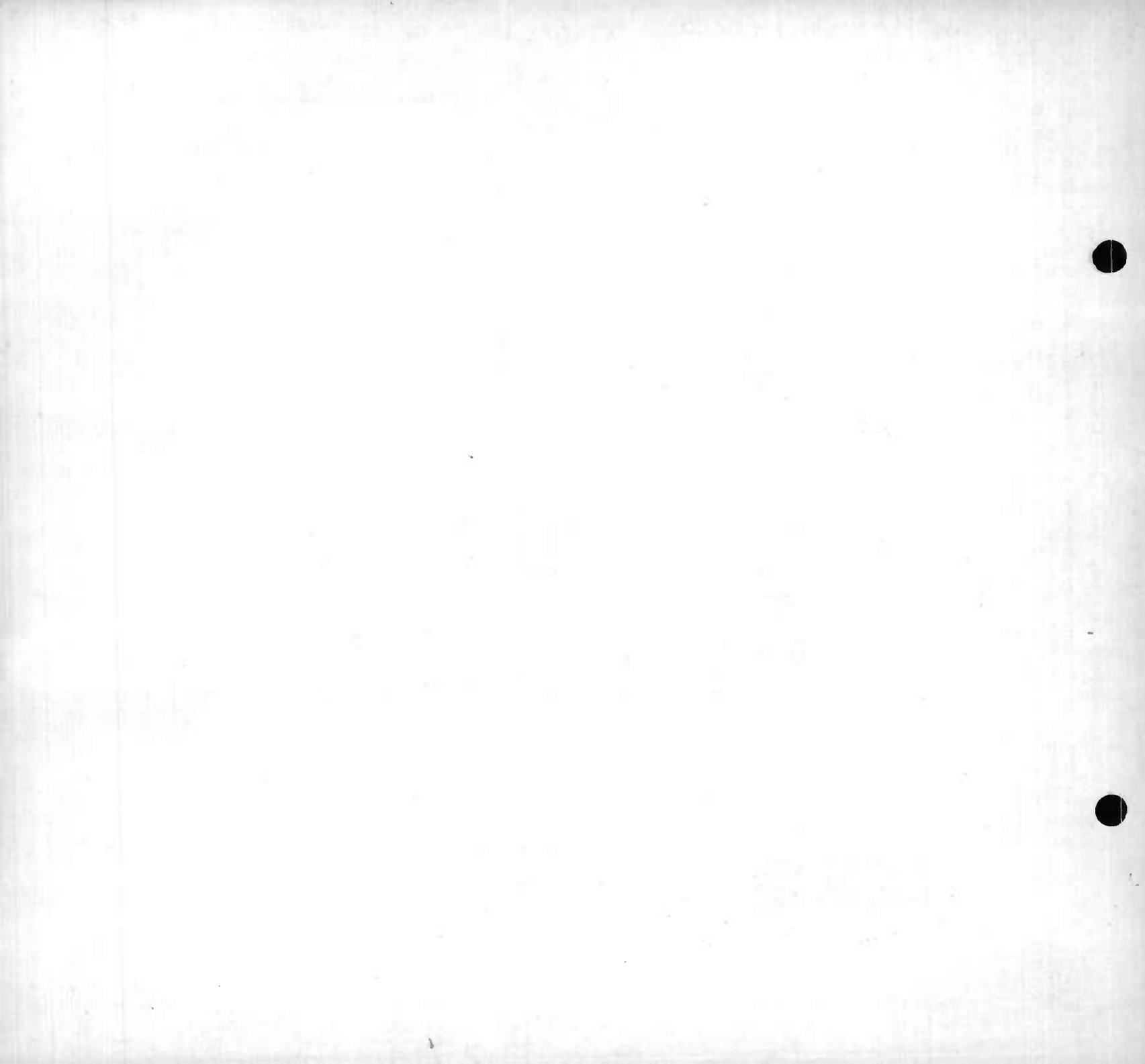
BIRTH NO. 65 8227		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65-05-18227	
1. NAME OF DECEASED (Type or Print) Anna Mead				2. DATE AND HOUR OF DEATH August 6, 1965			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Belvedere Nursing Home				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3617 Clifmar Road			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1/22/1883	9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Companion			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Romans			14. MOTHER'S MAIDEN NAME Elizabeth Scott				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 216-14-7783A		17. INFORMANT William Mead 3617 Clifmar Road Mrs. Betty Gruel		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) E 903.7 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO Bronchopneumonia (B) DUE TO Fracture of hip (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 4 days	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Belvedere N. Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Belvedere Home		21D. TIME OF INJURY (APPROX.) 7 12 65	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? fell to pavement		21G. DATE OF INJURY 27-17			
22. I certify that (I) (this hospital) attended the deceased from 1930 to August 5, 1965, and that (I) last saw the deceased alive on August 5, 1965, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.							
23A. SIGNATURE Dr. Milton Sherry				23B. DATE SIGNED 8/9/65			
23C. PHYSICIAN'S NAME (Type) Dr. Milton Sherry				23D. ADDRESS 11 E. Chase St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/9/65		24C. NAME of CEMETERY or CREMATORY Greenmount Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Jones		25C. FUNERAL DIRECTOR Edsworth Armacost		ADDRESS 4600 Liberty Heights	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>65-19532-65</u> <u>8228</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65</u> <u>8228</u>	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>BABY GIRL KENDALL</u>		2. DATE AND HOUR OF DEATH <u>8/5/65</u> <u>12:50</u> <u>A.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>JOHNS HOPKINS HOSPITAL</u> <u>CMS C PREMATURE NUR.</u>		A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>8-06</u>			
		D. STREET ADDRESS (If rural, give location) <u>1708 N. Broadway</u>			
5. SEX <u>F</u>	6. RACE <u>COLORED</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>—</u>	8. DATE OF BIRTH <u>8/5/65</u>	9. AGE (In years last birthday) <u>8</u> <u>30</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>CHARLES KENDALL</u>			
14. MOTHER'S MAIDEN NAME <u>DOROTHY</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>1708 N. BROADWAY</u>			
18. <u>773.51</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Cardio respiratory arrest</u> DUE TO (B) <u>Hyaline membrane disease</u> DUE TO (C) <u>Prematurity</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>8 hrs</u> <u>10 min</u> <u>8 hrs 30 min</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Respiratory distress</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>no</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) <u>no</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>no</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Work Not White At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3:15 Aug 5</u> 19 <u>65</u> to <u>12:50 Aug 5</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Aug 5</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Harriet W. Cousins</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/5/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>HARRIET W. COUSINS</u>		23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION REMOVAL (specify) <u>HOSPITAL DISPOSAL</u>		24B. DATE <u>8/6/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>JOHNS HOPKINS HOSPITAL</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE</u> <u>S. MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 9 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Feltner</u>		25C. FUNERAL DIRECTOR ADDRESS <u>HOSPITAL DISPOSAL</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 8229		CERTIFICATE OF DEATH		Registered No. 65 8229	
1. NAME OF DECEASED (Type or Print) <u>Mamie Kindervater</u>				2. DATE AND HOUR OF DEATH <u>4:00pm 8/5/65</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General Hospital Baltimore</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>11-01</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1301 St. Paul St. Earl G. Apts.</u>					
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>12/27/1881</u>	9. AGE (In years last birthday) <u>83</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Charles Kindervater</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Wolff.</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT			ADDRESS		
18. <u>451X-1810</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshterio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>ABdominal Aneurysm.</u> DUE TO (B) <u>ASHD.</u> DUE TO (C) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Carcinoma of Bladder</u>									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No.</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>8/5/65</u> to <u>8/5</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>8/5</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>J-Stephen Margolis</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/5/65</u>			
23C. PHYSICIAN'S NAME (Type) <u>J-Stephen Margolis</u>				23D. ADDRESS <u>Maryland General Hospital Balto, Md.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/7/65</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 9 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Inc. 1217 St. Paul St.</u>				ADDRESS <u>21202</u>	

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BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SMITH

ROBINSON

2. DATE AND HOUR PRONOUNCED DEAD

August 5, 1965

3:00 P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1013 S. Baylis Street

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1013 S. Baylis Street

5. SEX

Male

6. RACE

Caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

6-27-1888

9. AGE (In years
last birthday)

77

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

polisher

10B. KIND OF BUSINESS OR INDUSTRY

E. Stainless Steel

11. BIRTHPLACE (State or foreign country)

Braxton W. Va

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

?

Robinson

14. MOTHER'S MAIDEN NAME

Inatte

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

234I482I8

17. INFORMANT

Gertie Kingsley

ADDRESS

as above

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenio, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Bronchopneumonia.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes - Partial

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/5/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-7-65

23C. NAME of CEMETERY or CREMATORY

Gardens Of Faith

23D. LOCATION

(City, town, or county)

Baltimore, Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 9 1965

24B. NAME OF REGISTRAR

Robert E. Farley M.D.

24C. FUNERAL DIRECTOR

Walter Dalowski 1005 Dundalk Ave

ADDRESS

WALLER PAPER CO. MADE IN U.S.A.

MADE IN U.S.A.

MADE IN U.S.A.

MADE IN U.S.A.

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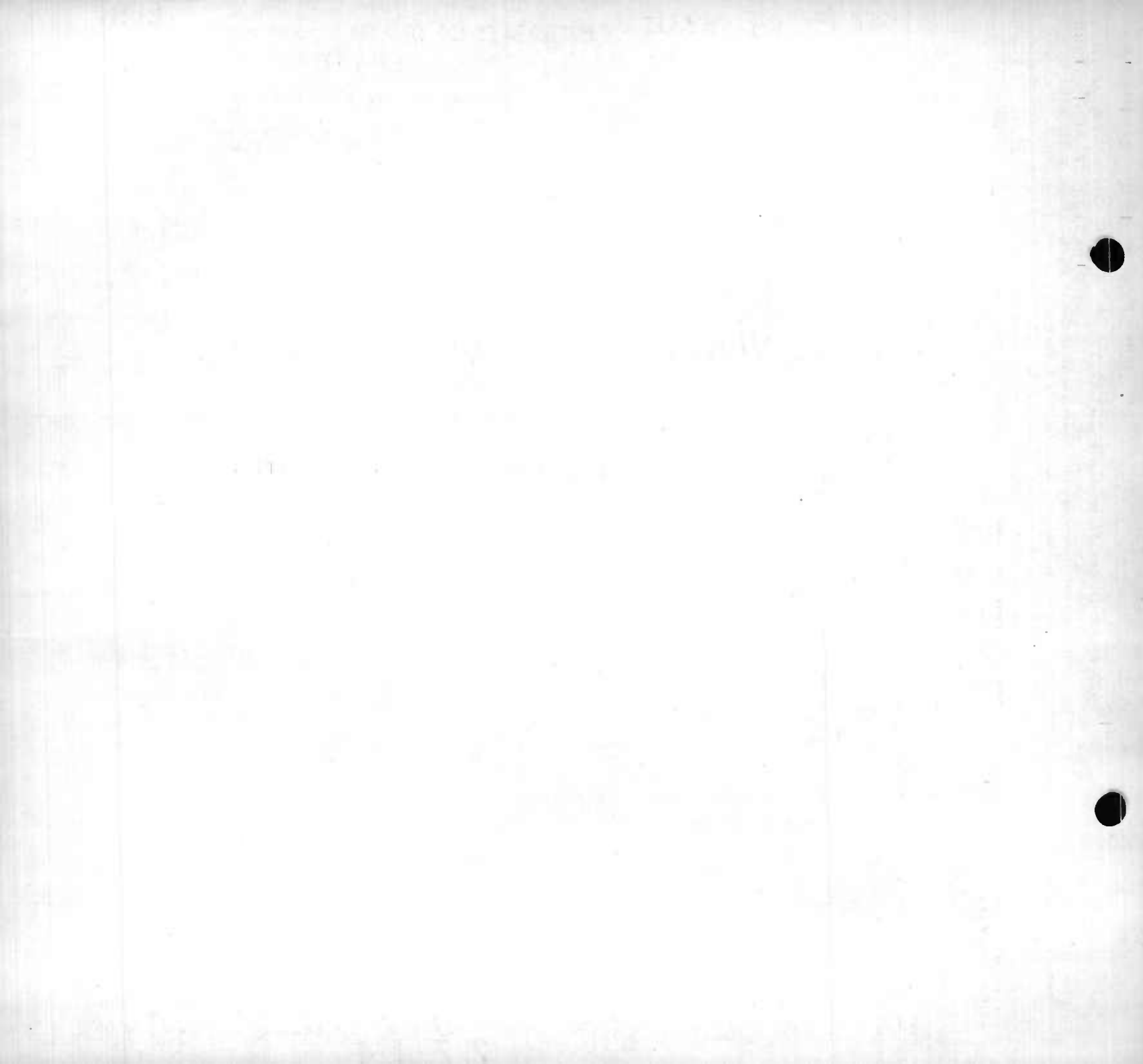
MADE IN U.S.A.

CASE RELEASED ON APPROVAL BY DR. HAUSER OF MEDICAL EXAMINER'S OFFICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65-05502 65 8231		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8231	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ANTHONY WILSON		2. DATE AND HOUR OF DEATH 8/5/65 3:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1204 E MADISON			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 3/14/15	9. AGE (In years last birthday) 5 MONTHS	If Under 1 Yr. Months Days 4 25 If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Allison Wilson			
14. MOTHER'S MAIDEN NAME Willie Mae Hodges		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. 772.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) SEVERE CHRONIC MALNUTRITION (B) DUE TO (C) DUE TO (D) DUE TO (E) DUE TO (F) DUE TO (G) DUE TO (H) DUE TO (I) DUE TO (J) DUE TO (K) DUE TO (L) DUE TO (M) DUE TO (N) DUE TO (O) DUE TO (P) DUE TO (Q) DUE TO (R) DUE TO (S) DUE TO (T) DUE TO (U) DUE TO (V) DUE TO (W) DUE TO (X) DUE TO (Y) DUE TO (Z) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 772.0	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 8-5-63 19 to 8-5-65 19 that (I) (we) lost saw the deceased alive on 8-5-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Celia A. Wilson		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-5-65	
23C. PHYSICIAN'S NAME (Type) G2405A-MILGRAM		23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-9-65		24C. NAME of CEMETERY or CREMATORY MT Calvary Cem.	
24D. LOCATION (City, town, or county) (State) Brooklyn Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965			
25B. NAME OF REGISTRAR Robert E. Fagundes		25C. FUNERAL DIRECTOR ADDRESS E. J. Wilson 1000 Broadway Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8232				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8232	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BENNEY STATION				2. DATE AND HOUR OF DEATH 7:20 PM 8/6/65 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL				A. STATE MD B. COUNTY 25-32			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 2908 Carver Rd.			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH June 6-1896	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Hamilton N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bennie Station				14. MOTHER'S MAIDEN NAME Alise Burnett			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. ?		17. INFORMANT Moris Smith		ADDRESS Same	
18. 433.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARRHYTHMIA, suspected				INTERVAL BETWEEN ONSET AND DEATH unknown			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bilateral Bronchopneumonia Urinary tract Infection							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that at (this hospital) attended the deceased from 7/27 19 65 to 8/6 19 65 , that (I) was last saw the deceased alive on 6:10 PM 19 65 and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) (did not) view the body after death.							
23A. SIGNATURE Bruce A. Brian M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/6/65	
23C. PHYSICIAN'S NAME (Type) BRUCE A. BRIAN M.D.				23D. ADDRESS UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-12-1965		24C. NAME OF CEMETERY or CREMATORY Burnetts Creek		24D. LOCATION (City, town, or county) (State) North Carolina	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Shanning J. Horne		ADDRESS North Carolina	

65 8233

BIRTH NO. 65-04159

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65-8233

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

2. DATE AND HOUR PRONOUNCED DEAD

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

5. SEX

6. RACE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

19. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion
resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

ASSOCIATE MEDICAL EXAMINER

DATE SIGNED

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

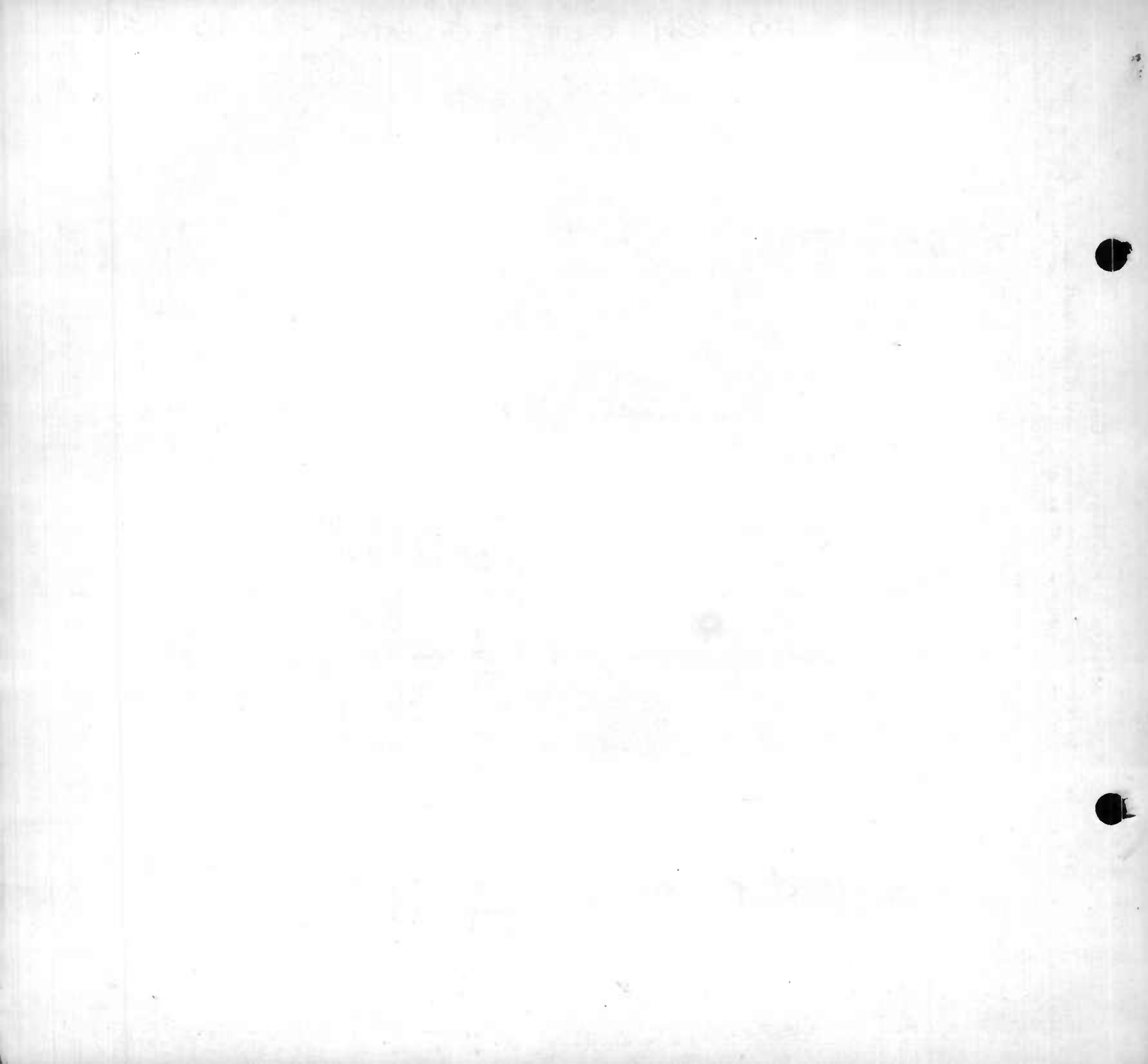
ADDRESS

VALLEY POLICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

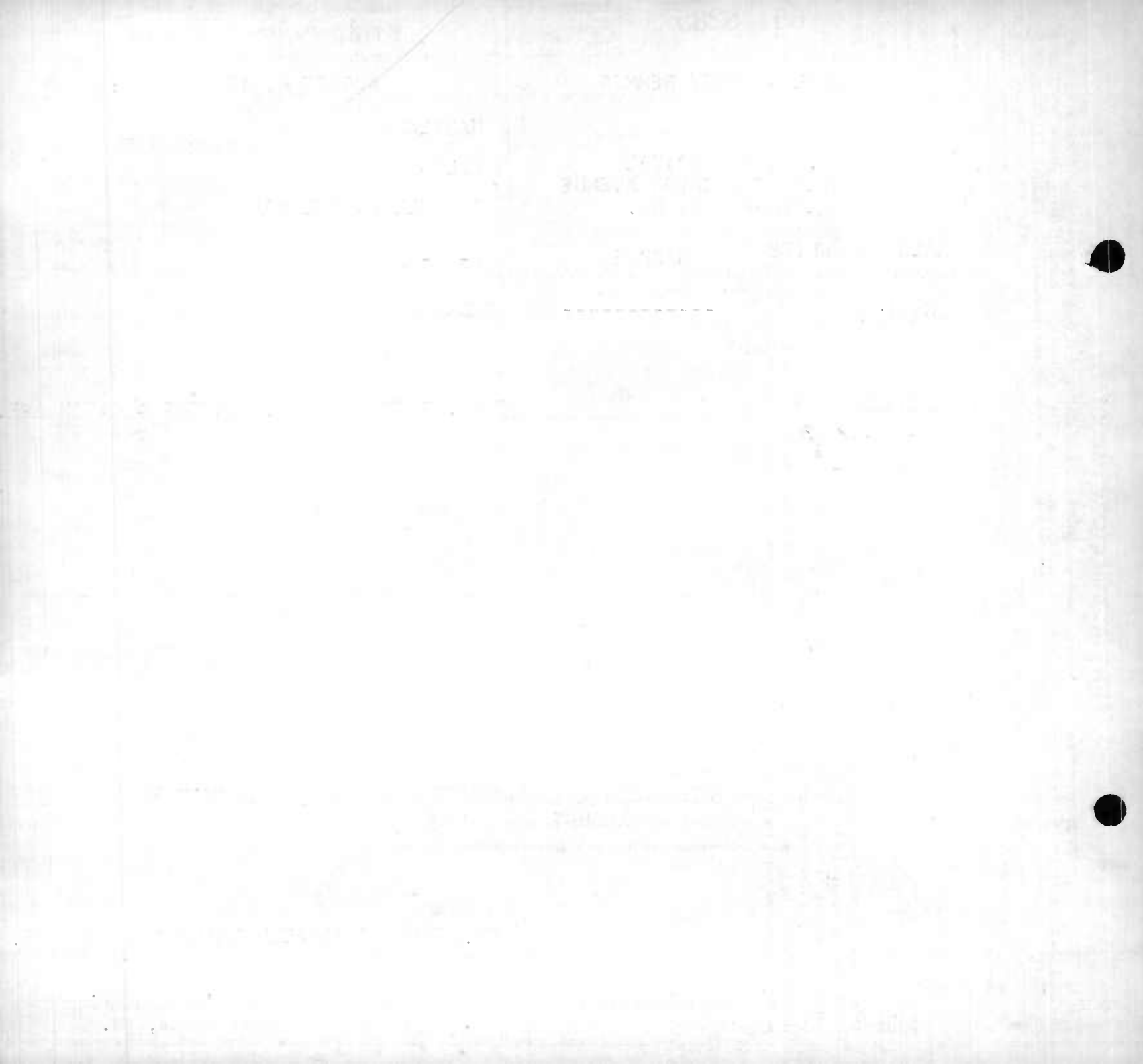
BIRTH NO. 65 8234		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8234	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Florence Rogers</i>			July 27, 1965 3 20 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>2046 Orleans St</i>			A. STATE <i>Maryland</i> B. COUNTY <i>6-04</i>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		
			D. STREET ADDRESS (If rural, give location) <i>2046 Orleans St.</i>		
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W</i>	8. DATE OF BIRTH <i>MAY 16, 1904</i>	9. AGE (In years lost birthday) <i>61</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Miles T. Nixon</i>			14. MOTHER'S MAIDEN NAME <i>Florence Nixon</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>218-22-4748</i>		17. INFORMANT ADDRESS <i>Hemeritta Williams same</i>
18. <i>287X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO <i>Coronary Artery Disease</i> (B) DUE TO <i>Essential Hypertension</i> (C) DUE TO <i>Obesity</i>		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>July 26, 1965</i> to <i>July 27, 1965</i> , that (I) (we) last saw the deceased alive on <i>July 26, 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Albert F. Cooper</i>				23B. DATE SIGNED <i>8/5/1965</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<i>Burial</i>		<i>8-2-65</i>		<i>Balto. Nat. Cem.</i>	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS			
<i>Baltimore Md.</i>		<i>7707 Wilson 1000 Brantley Ave.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 9 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

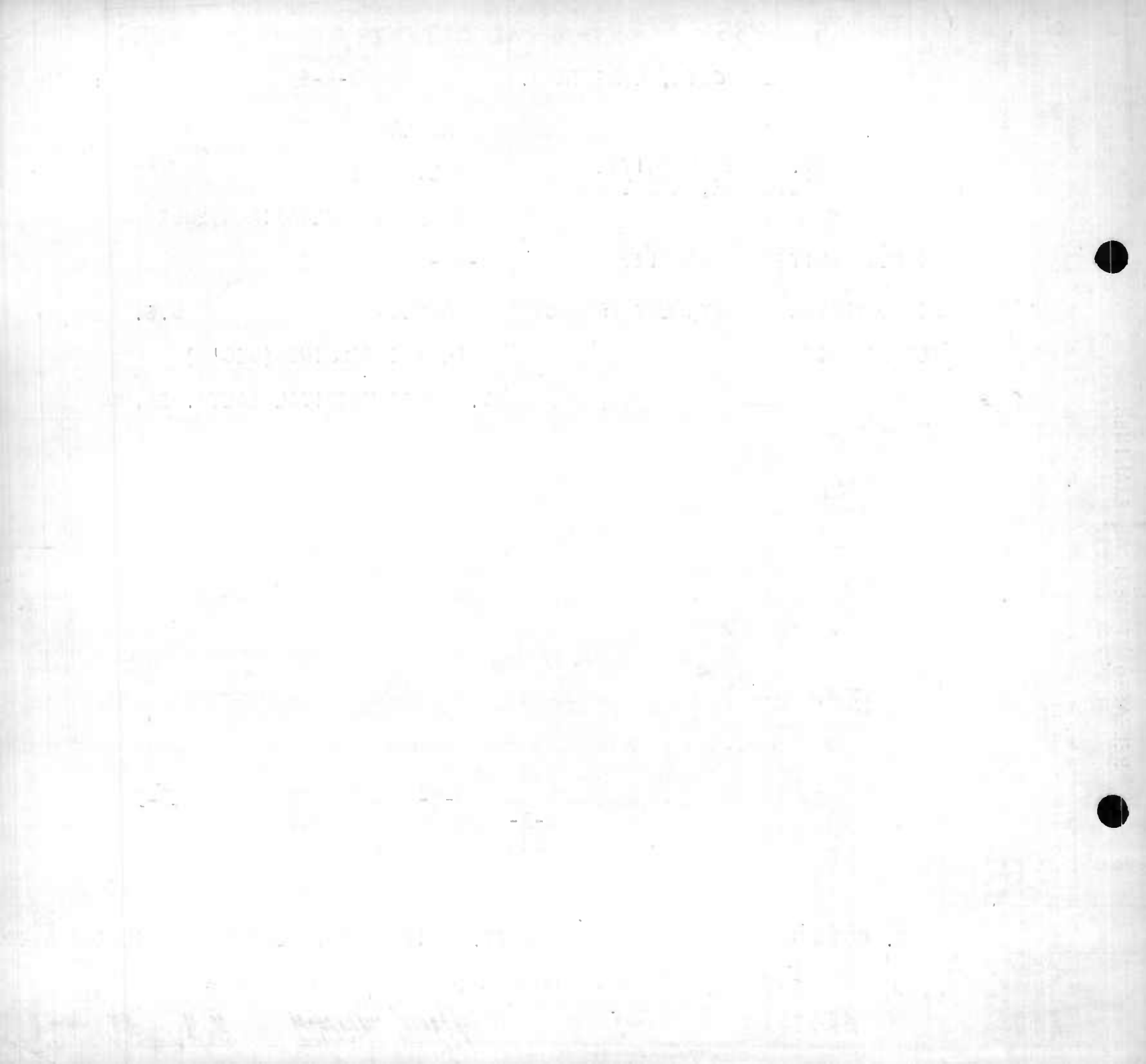
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8235				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8235	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
ADOLPH HENRY REMMER				AUGUST 4, 1965 8:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE 29, MD.				MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				FULTON			
				D. STREET ADDRESS (If rural, give location)			
				PINDELL SCHOOL ROAD			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. If Under 1 Yr. Months Days Hours Min.		
MALE	WHITE	MARRIED	1-30-83	82			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
RETIRED		Painter		GERMANY		U S A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
August Remmer				Ida Honburg			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
UNKNOWN		217 125 951A		ST. AGNES HOSPITAL, WILKENS & CATON AVE.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
				Hemorrhagic enteritis, Etc.			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Congestive Heart Failure			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from AUGUST 4 19 65 to AUGUST 4 19 65, that (I) (we) last saw the deceased alive on AUGUST 4 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Vicente G. Raden M.D.				8-5-65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				M.D. ST. AGNES HOSPITAL, WILKENS & CATON AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/7/65		Fort Lincoln Cemetery		Colmar Manor, Maryland.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
AUG 9 1965		Robert E. Farkes		F. Gasch's Sons. Hyattsville, Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

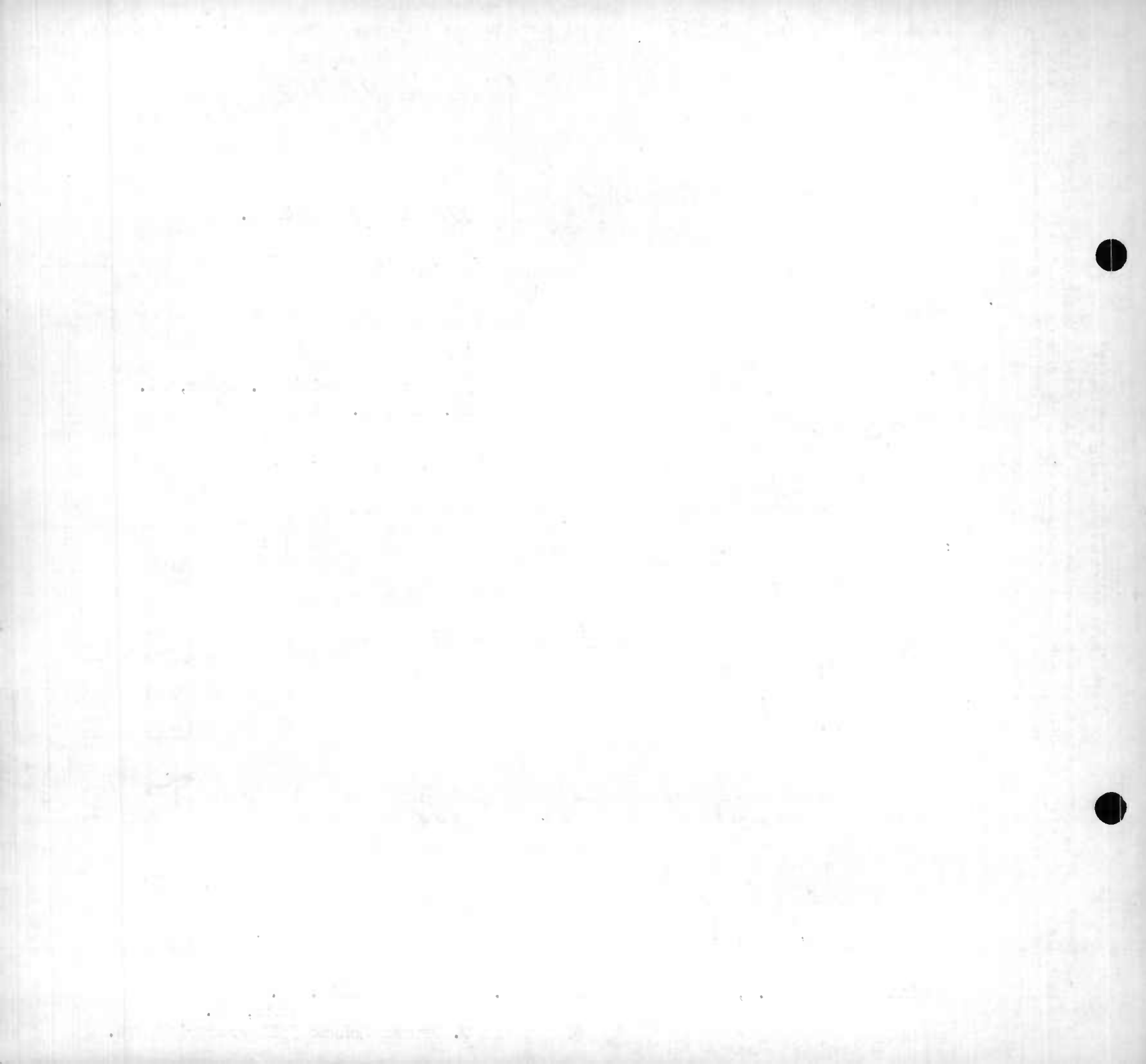
BIRTH NO. 65 8236				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8236	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) LA CORTE, LORETTA J.				2. DATE AND HOUR OF DEATH 8-3-65		5:10AM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL BALTIMORE, MARYLAND		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY BALTO	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 2843 PENNSYLVANIA AVENUE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-17-35	9. AGE (In years lost birthday) 30	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DEMONSTRATOR		10B. KIND OF BUSINESS OR INDUSTRY STANLEY PRODUCTS		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JESSIE SMITH				14. MOTHER'S MAIDEN NAME ANNA E JENKINS (DEC'D)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. 215-30-2488		17. INFORMANT ADDRESS ST. AGNES HOSPITAL BALTO. 29, MD			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Intracranial Hemorrhage (sub-arachnoid) (B) DUE TO Ruptured Aneurysm (C) Suspect		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from 8-2-19 65 to 8-3-19 65, that (X) (we) last saw the deceased alive on 8-3-19 65 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Benjamin C. Guzman M.D.				23B. DATE SIGNED 8-3-65			
23C. PHYSICIAN'S NAME (Type) B. GUZMAN		23D. ADDRESS M.D. ST. AGNES HOSPITAL; CATON & WILKENS AVES #29					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-6-65		24C. NAME OF CEMETERY or CREMATORY Granite Presbyterian Cemetery		24D. LOCATION (City, town, or county) (State) Woodstock, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Farker M.D.		25C. FUNERAL DIRECTOR Harry Haight		ADDRESS Sykesville, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

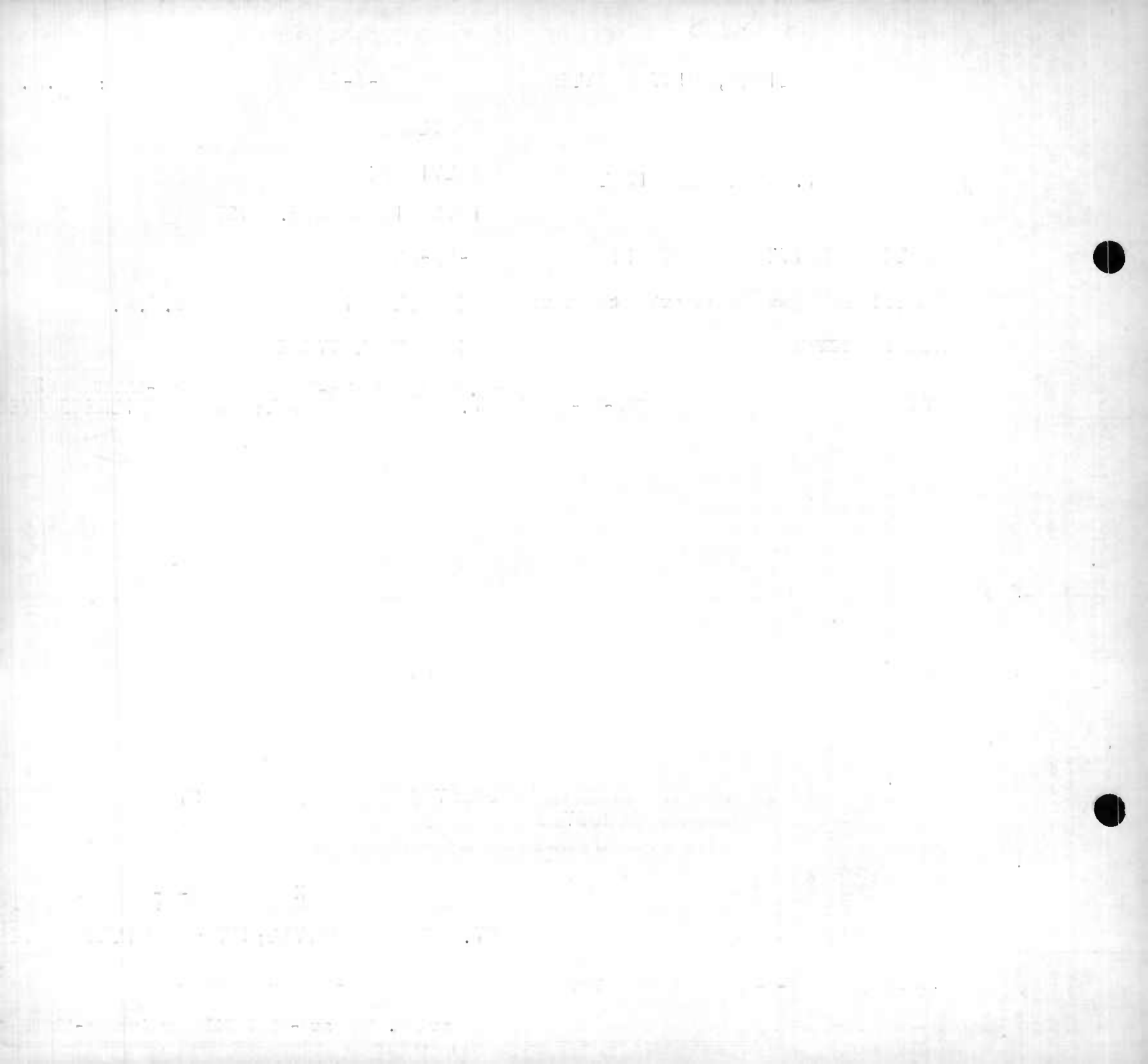
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 8237		CERTIFICATE OF DEATH		Registered No. 65 8237	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Florence Fisher</i>		2. DATE AND HOUR OF DEATH <i>5 Aug 65</i> <i>8¹⁰ P</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Fayette Convalescent Home</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>Maryland</i>		B. COUNTY <i>20-01</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
D. STREET ADDRESS (If rural, give location) <i>3508 Old Frederick Rd.</i>		5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>		B. DATE OF BIRTH <i>11/26/78</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		9. AGE (In years last birthday) <i>86</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>William Martin</i>		14. MOTHER'S MAIDEN NAME <i>Annie Martin</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>3508 Old Frederick Rd. Balto, Md.</i> <i>Mrs. Elmer L. Wolff</i>	
18. <i>734.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Congestive Heart Failure</i>				(A) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <i>3 mos</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO					
(C) DUE TO									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>ASCD (cerebral) Cataracts 51x53 Tga @ 55 yrs abd abscess 21x14x50</i>									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>Jun 19 62</i> to <i>5 Aug 19 65</i> , that (I) (we) last saw the deceased alive on <i>5 Aug 19 65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>J. Hulla</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5 Aug 65</i>			
23C. PHYSICIAN'S NAME (Type) <i>J. Hulla</i>		M.D.		23D. ADDRESS <i>2214 E Fayette St 21231</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Aug 9, 1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>london Park Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Balto, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 9 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>G. Truman Schwab</i>		ADDRESS <i>3512 Frederick Ave.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

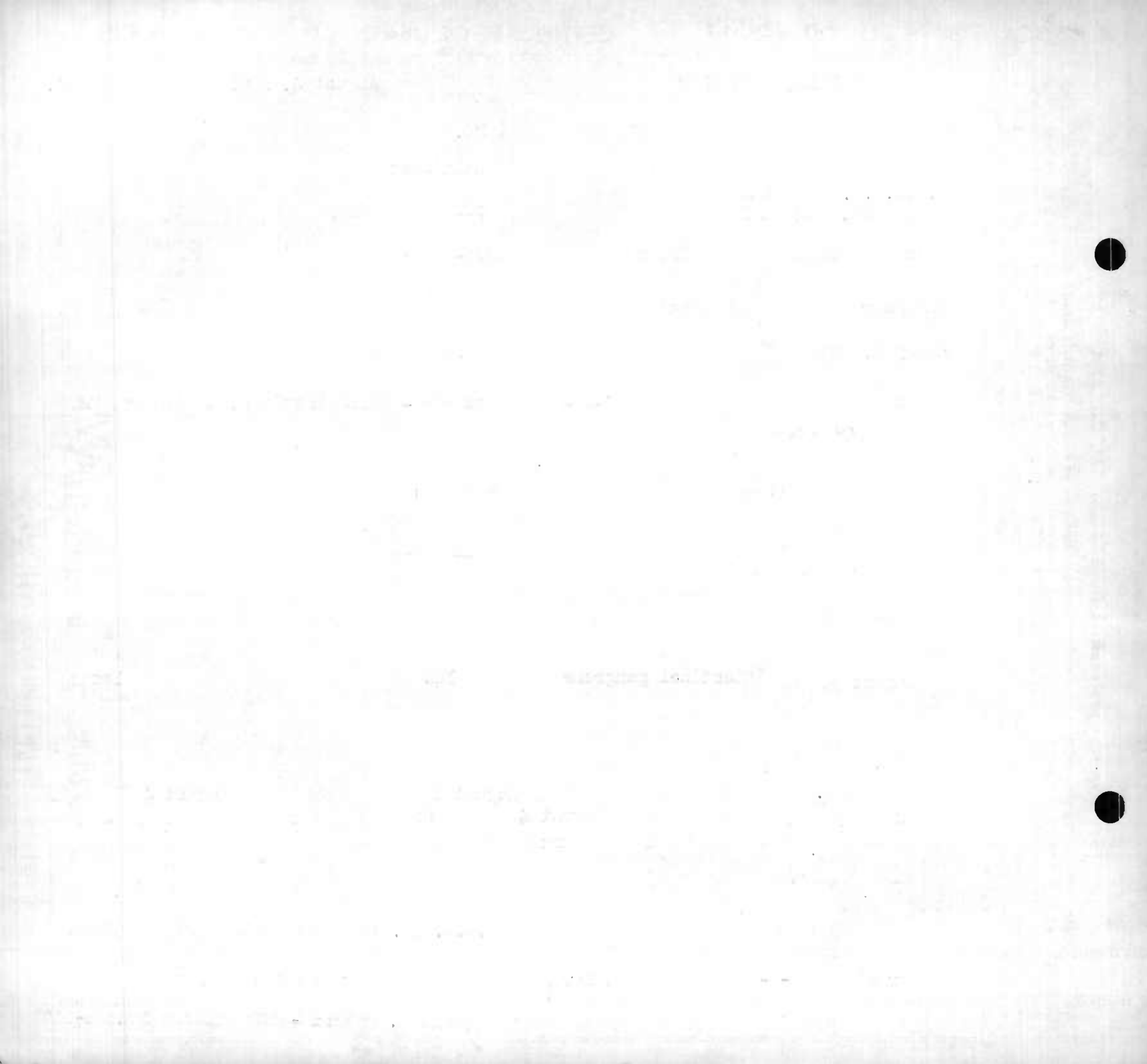
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 8238		CERTIFICATE OF DEATH				Registered No. 65 8238			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SLIFER, VICTOR GALEN				2. DATE AND HOUR OF DEATH 8-6-65 10:55A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1812 WINANS AVE. #27			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7-29-92	9. AGE (In years lost birthday) 73	10. CITIZEN OF WHAT COUNTRY? U.S.A.		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Buyer			10B. KIND OF BUSINESS OR INDUSTRY Department Store			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME HENRY SLIFER			14. MOTHER'S MAIDEN NAME EMMA SCHLOTTERER			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES			
16. SOCIAL SECURITY NO. 215-10-1886A			17. INFORMANT Mrs. Flora Slifer-1812 Winans Ave-21227 #29			ADDRESS ST. AGNES HOSPITAL; CATON & WILKENS AVES			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 331X1 Cerebro-Vascular Accident 24 hours						INTERVAL BETWEEN ONSET AND DEATH 24 hours			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from AUGUST 5 19 65 to AUGUST 6 19 65, that (I) (we) last saw the deceased alive on AUGUST 6 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Robert E. Fisher						23B. DATE SIGNED 8-6-65			
23C. PHYSICIAN'S NAME (Type) M.D.						23D. ADDRESS ST. AGNES HOSPITAL; CATON & WILKENS AVES #29			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-9-65		24C. NAME of CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Howard H. Hubbard-4107 Wilkens Avenue-21229		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8239		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8239	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MERRILL HARD BUSH			2. DATE AND HOUR OF DEATH August 4, 1965 9:05 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U.S.P.H.S. Hospital Baltimore, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Md. 2-13 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 522 S. Broadway		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH Sep-9-1896	9. AGE (In years last birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY Seafarer		11. BIRTHPLACE (State or foreign country) Florida	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Henry H. Bush		
14. MOTHER'S MAIDEN NAME Alice Bethel			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None		
16. SOCIAL SECURITY NO. 214-10-0212			17. INFORMANT ADDRESS Records - USPHS Hospital, Baltimore, Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO Infarction of the Small Bowel (B) DUE TO Circulatory Inadequacy (C) _____		INTERVAL BETWEEN ONSET AND DEATH days
19A. DATE OF OPERATION 3 August 3, 1965			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal gangrene		20A. AUTOPSY? (Yes or No) Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			22. I certify that (X) (this hospital) attended the deceased from August 2 1965 to August 4 1965, that (X) (we) last saw the deceased alive on August 4 1965 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.		
23A. SIGNATURE Thomas Lau			23B. DATE SIGNED 8/6/65		23C. PHYSICIAN'S NAME (Type) THOMAS LAU
23D. ADDRESS U.S.P.H.S. Hospital, Baltimore, Maryland			24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 8-9-65			24C. NAME OF CEMETERY or CREMATORY Loudon Park		
24D. LOCATION Baltimore, Maryland			25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		
25B. NAME OF REGISTRAR Robert S. Fink			25C. FUNERAL DIRECTOR Howard H. Hubbard-4107 Wilkens Avenue-21229		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8240		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8240	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) LENA CONRAD			2. DATE AND HOUR OF DEATH AUG 4, 1965 11:40 p.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ANDERSON CONV. HOME			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO. CO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) CATONSVILLE 63-00 D. STREET ADDRESS (If rural, give location) 58 MELLOR AVE.		
5. SEX F.	6. RACE W.	7. MARRIED NEVER MARRIED WIDOWED DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 11/21/86	9. AGE (In years lost birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CANDY MAKER		10B. KIND OF BUSINESS OR INDUSTRY RET.	11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME HENRY CONRAD			14. MOTHER'S MAIDEN NAME ELIZABETH MILLER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS MRS. ARLETTA SCHISLER		
18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) CEREBRAL HEMORRHAGE DUE TO (B) DUE TO (C) ARTERIOSCLEROSIS, GENERALIZED		INTERVAL BETWEEN ONSET AND DEATH 2 days. YEARS
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from OCT. 19 52 to AUG. 3, 1965 , that (I) (we) last saw the deceased alive on AUG. 3, 1965 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Gilbert E. Rudman			23B. DATE SIGNED Aug. 5, 1965		
23C. PHYSICIAN'S NAME (Type) Gilbert E. Rudman			23D. ADDRESS 2517 W. Baltimore St.		
24A. BURIAL CREMATION; RECEIVED (Specify) BURIAL	24B. DATE 8/5/65	24C. NAME OF CEMETERY or CREMATORY WESTERN	24D. LOCATION (City, town, or county) (State) BALTO. MD		
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR ADDRESS F.S. MAGUIRAB 301 FREDERICK Rd 21228		

October 1900

1900

1900

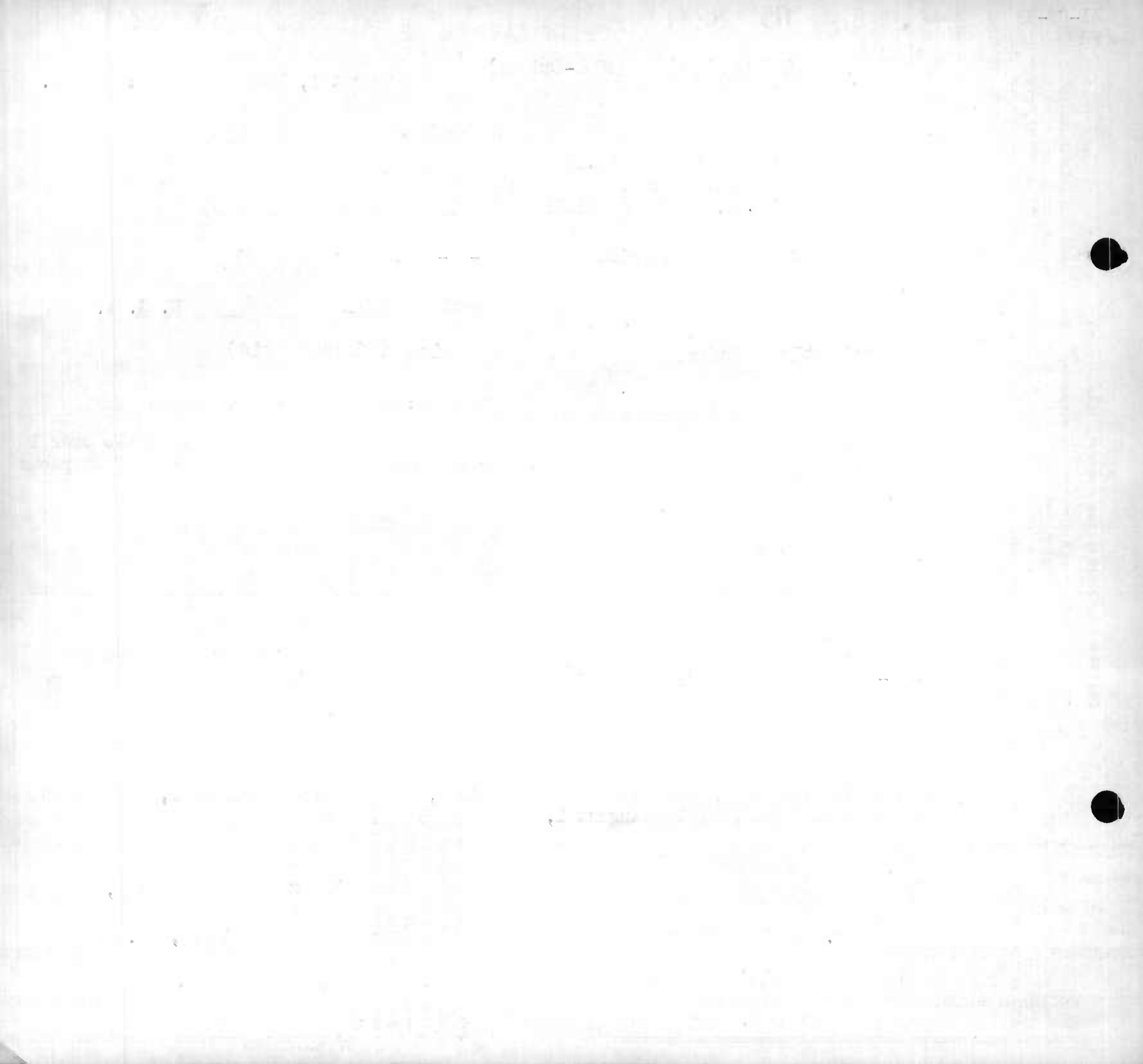
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

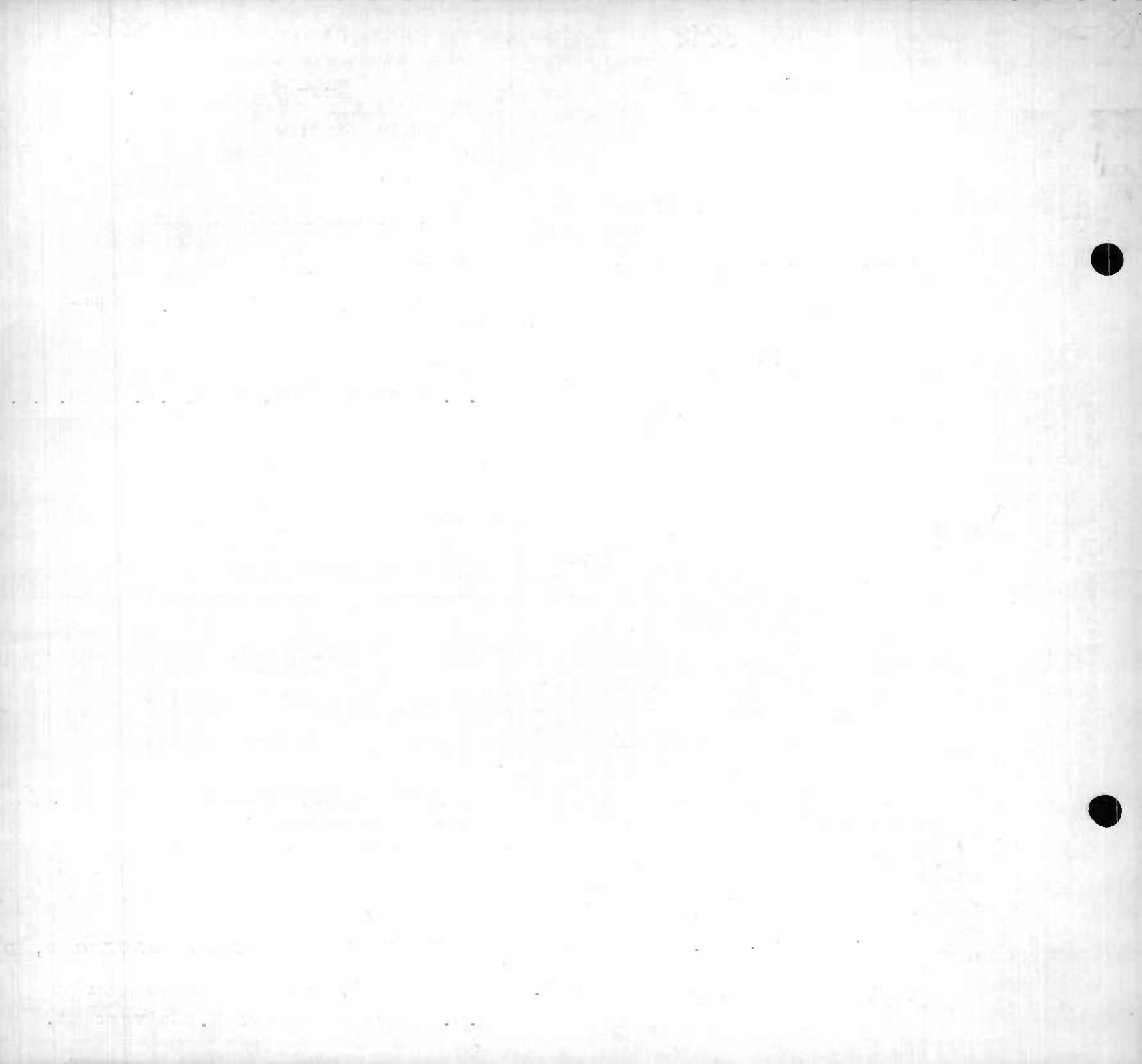
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8241	
BIRTH NO. 65 8241				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) (Celestine) Lessie Taylor (NEE-Dukes)				August 1, 1965 5:20 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE Maryland B. COUNTY Baltimore	
5. SEX Female				6. DATE OF BIRTH 6-12-1922	
7. RACE Negro				9. AGE (In years last birthday) 43	
10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married				11. BIRTHPLACE (State or foreign country) South Carolina	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10B. KIND OF BUSINESS OR INDUSTRY				14. MOTHER'S MAIDEN NAME Dina (Diana David)	
13. FATHER'S NAME Priestly Dukes				17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) Cancer of Lung DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH A little over 1 Year of Symptoms	
19A. DATE OF OPERATION 2-24-1965				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Diagnosis of Carcinoma	
20A. AUTOPSY? (Yes or No) Yes				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 5, 19 65 to August 1, 19 65, that (I) (we) last saw the deceased alive on August 1, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Donald Baltzan				23B. DATE SIGNED August 1, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. Donald Baltzan				23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 8/7/65	
24C. NAME OF CEMETERY or CREMATORY MOUNT AUBURN CEM.				24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965				25B. NAME OF REGISTRAR ISAIAH L. BROWN & SON	
25C. FUNERAL DIRECTOR ADDRESS 123 W. MONTGOMERY ST					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

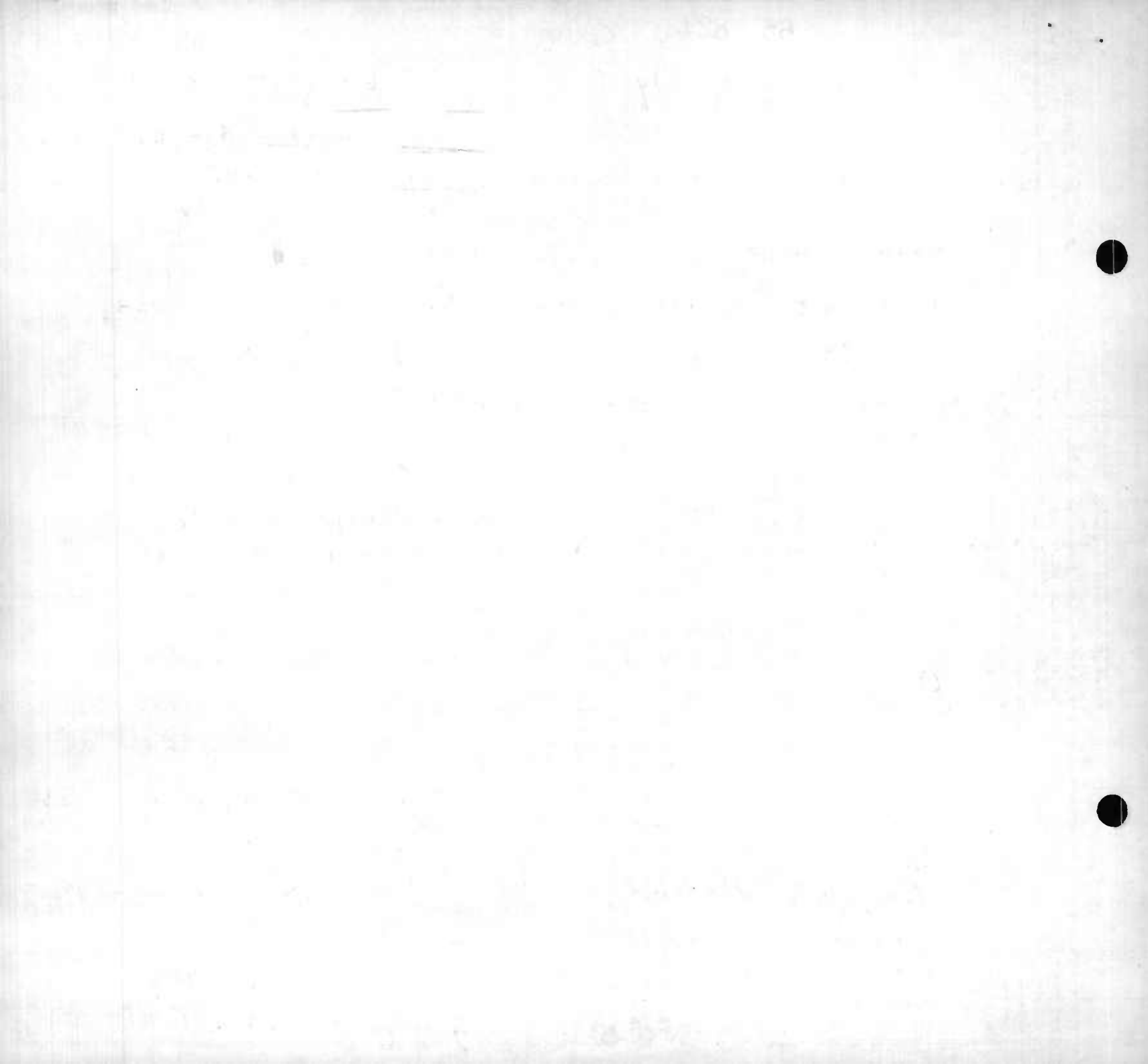
BIRTH NO. 65 8242		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8242	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) MARUJA GOMEZ		
2. DATE AND HOUR OF DEATH 8-9-65 12. AM.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE SOUTH AMERICA B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) CALI, COLUMBIA D. STREET ADDRESS (If rural, give location) AVE. DE LAS AMERICAS 201		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 12-20-1903	9. AGE (In years lost birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Manizales, Columbia	
12. CITIZEN OF WHAT COUNTRY? S. America		13. FATHER'S NAME CARLOS MENJIA		14. MOTHER'S MAIDEN NAME TERESA OCHOA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Dr. L. Gomez 99 Webster St, N.E. Wash. D.C.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Acute pulmonary edema (B) ASCVD (C)		
INTERVAL BETWEEN ONSET AND DEATH 4 hrs			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Aug 2 1965 to Aug 9 1965, that (I) (we) last saw the deceased alive on Aug 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE William B. Cutts M.D.			23B. DATE SIGNED 8.9.65		
23C. PHYSICIAN'S NAME (Type) DR. WILLIAMS CUTTS			23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL BALTIMORE, MD		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/65		24C. NAME of CEMETERY or CREMATORY Cali.	
24D. LOCATION (City, town, or county) Cali, Columbia South America		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR H.W. Mears & Son 805 N. Calvert St.	
25C. FUNERAL DIRECTOR ADDRESS		25D. NAME OF REGISTRAR			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

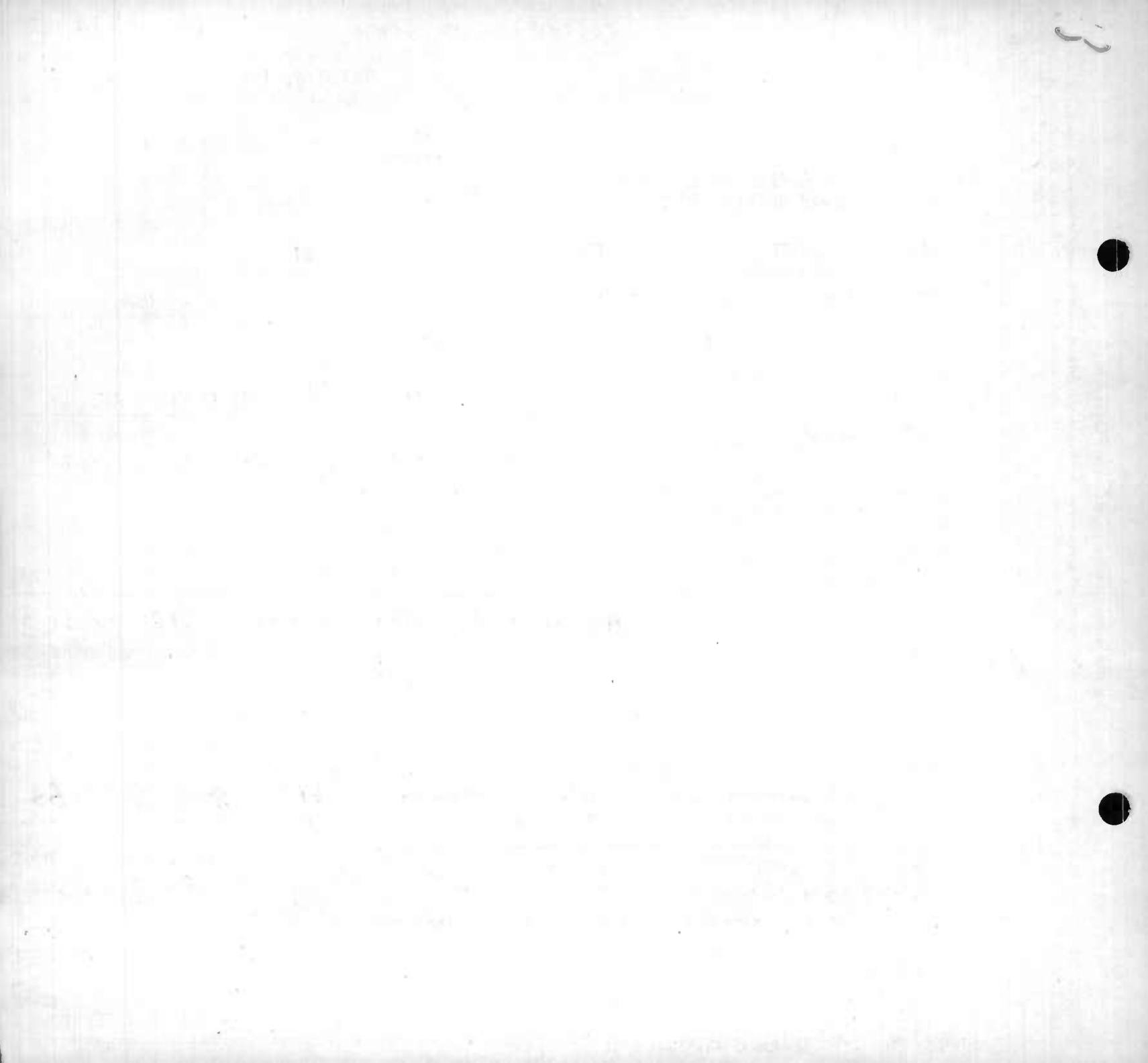
BIRTH NO. 65 8243		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8243	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Blumberg, Ely T.</u>		2. DATE AND HOUR OF DEATH <u>6 August 1965</u> <u>11</u> <u>P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI HOSPITAL OR BALTIMORE</u>		CITY <u>BALTIMORE</u> (If outside city limits, write RURAL and give township) STATE <u>MARYLAND</u> (If rural, give location) <u>2806 ROCKROSE AVE</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>9-28-1910</u>	9. AGE (In years lost birthdate) <u>54</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>DRUG RETAIL</u>		11. BIRTHPLACE (State or foreign country) <u>CHATTANOOGA TENNESSEE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Joseph Blumberg</u>		14. MOTHER'S MAIDEN NAME <u>SARAH R. FLAKS</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>218-32-1223</u>		17. INFORMANT <u>patient RECORDS</u> ADDRESS	
18. <u>592X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <u>UREMIA</u> DUE TO (B) <u>Glomerulonephritis, chronic</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work At <input type="checkbox"/> While Not At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>August 1</u> <u>1965</u> to <u>August 6</u> <u>1965</u> , that (I) (we) last saw the deceased alive on <u>6 August</u> <u>1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Harry M. Walen</u> M.D.		23B. DATE SIGNED <u>6 August 1965</u>		23C. PHYSICIAN'S NAME (Type) <u>HARRY M. WALEN</u> M.D.	
23D. ADDRESS <u>SINAI HOSPITAL</u>		24A. BURIAL CREMATION, (Specify) <u>BURIAL</u>			
24B. DATE <u>8/8/65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>SHAAREI ZION</u>		24D. LOCATION (City, town, or county) (State) <u>ROSEDALE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 9 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fink</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SQL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

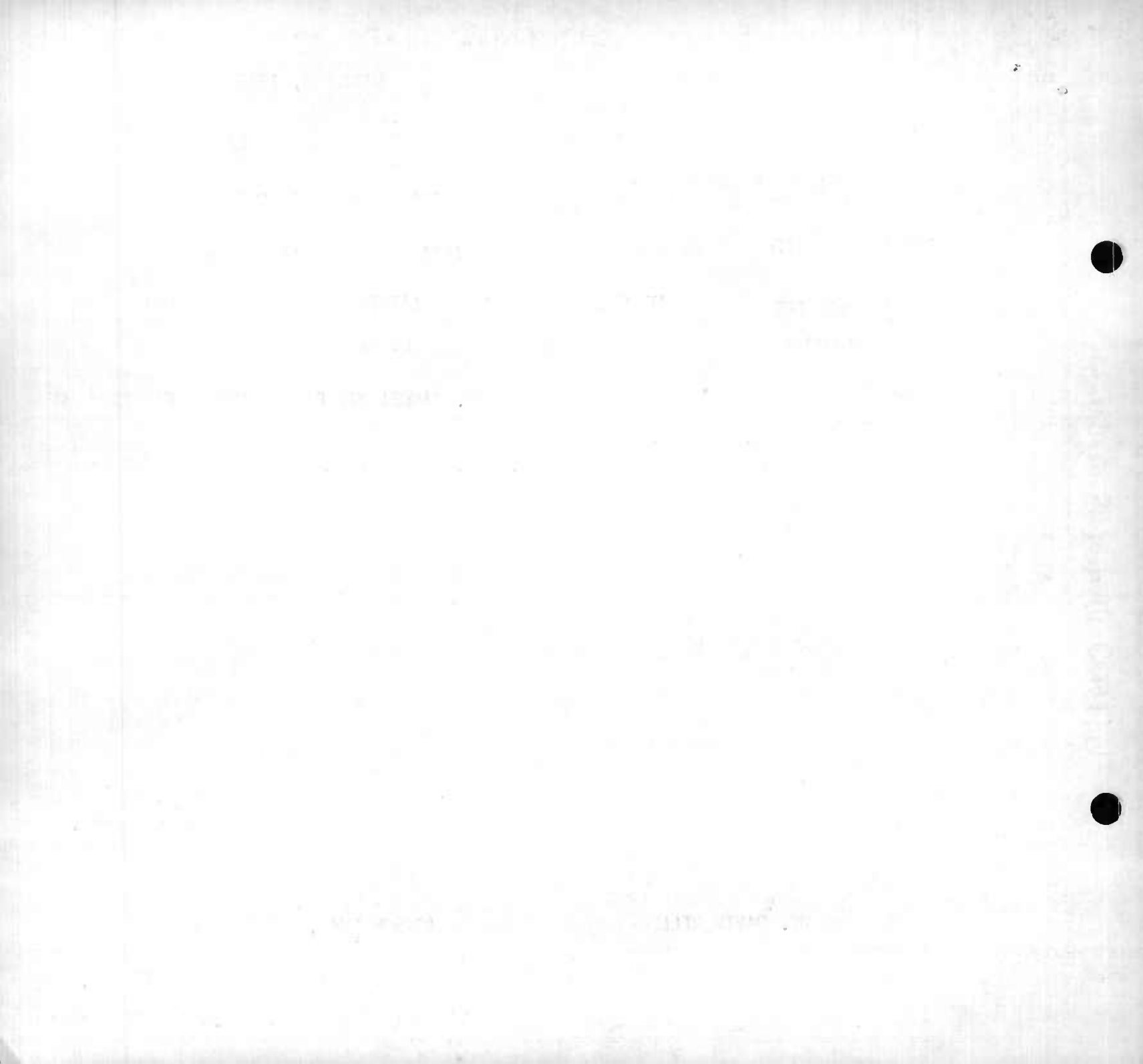
BALTIMORE CITY HEALTH DEPARTMENT															
BIRTH NO.					CERTIFICATE OF DEATH					Registered No. 65 8244					
M.E. CASE NO.					1. NAME OF DECEASED					2. DATE AND HOUR OF DEATH					
(Type or Print)					MEYER FISHMAN					AUGUST 6, 1965 1-3 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)										A. STATE B. COUNTY					
FRIEDLERS NURSING HOME 2449 SHIRLEY AVENUE										MARYLAND BALTIMORE					
D. STREET ADDRESS (If rural, give location)										4003 ELDORADO AVENUE					
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
MALE		WHITE		MARRIED				81							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
RETIRED GROCER				RETAIL				RUSSIA				USA			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME									
?						TOBA ?									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
NO						NO		MRS. TILLIE FISHMAN 4003 ELDORADO AVE							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)										CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)										(A) Cancer descending Colon				1 month	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										Arteriosclerotic heart disease				10 yrs	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0								NO							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?							
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>											
22. I certify that (I) (this hospital) attended the deceased from January 19 61 to August 6 19 65, that (I) (we) last saw the deceased alive on July 30 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE										23B. DATE SIGNED					
DR. GEORGE M. RAMAPURAM										8-7-65					
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS					
DR. GEORGE M. RAMAPURAM										3502 CROYDON ROAD					
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME of CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)					
BURIAL				8/8/65		KNESSETH ISRAEL KOLK WOLYN				BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS							
AUG 9 1965				Robert E. Fisher, M.D.				SQL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD							



FUNERAL DIRECTOR: IMPORTANT

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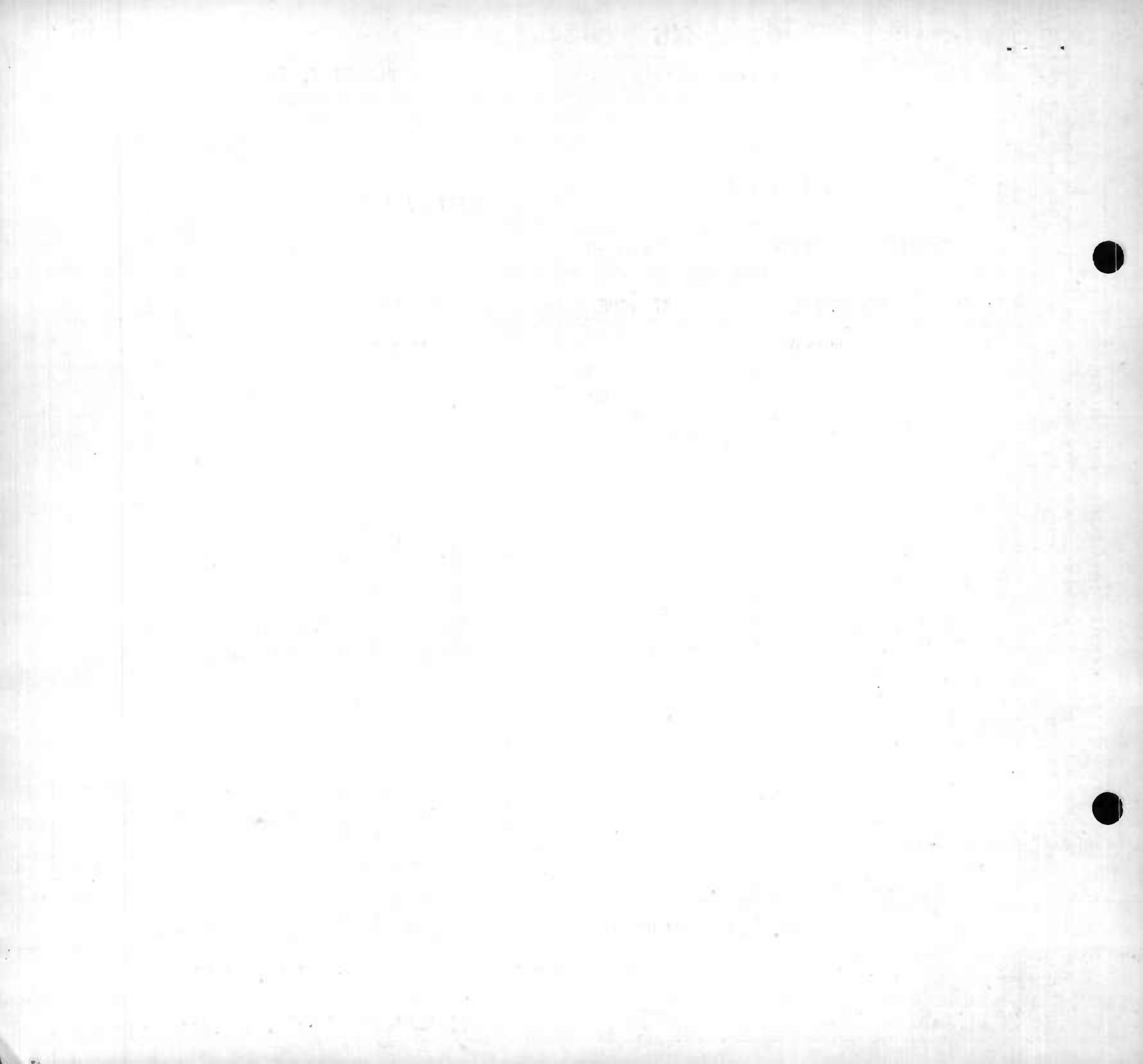
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 8245		CERTIFICATE OF DEATH		65 8245	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) REBECCA DAY			2. DATE AND HOUR OF DEATH AUGUST 7, 1965 2 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BELVEDERE NURSING HOME GREENSRRING & BELVEDERE AVES			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3720 W GARRISON AVENUE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED DIVORCED (specify)	8. DATE OF BIRTH 1881	9. AGE (In years last birthday) 84	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) LATVIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	17. INFORMANT MR. SAMUEL MICHELSON ADDRESS 3720 W GARRISON AVE		
18. 2000.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Ret. carcinoma of the stomach ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 8 months
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from May 1965 to Aug 7 1965 , that (I) (we) last saw the deceased alive on Aug. 1 1965 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David I. Miller DR. DAVID MILLER				23B. DATE SIGNED Aug 7-65	
23C. PHYSICIAN'S NAME (Type) DR. DAVID MILLER		23D. ADDRESS LINSON ROAD, OWINGS MILLS			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 8/8/65	24C. NAME OF CEMETERY or CREMATORY OHEL YAKOV	24D. LOCATION (City, town, or county) (State) HERRING RUN BALTIMORE, MD		
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

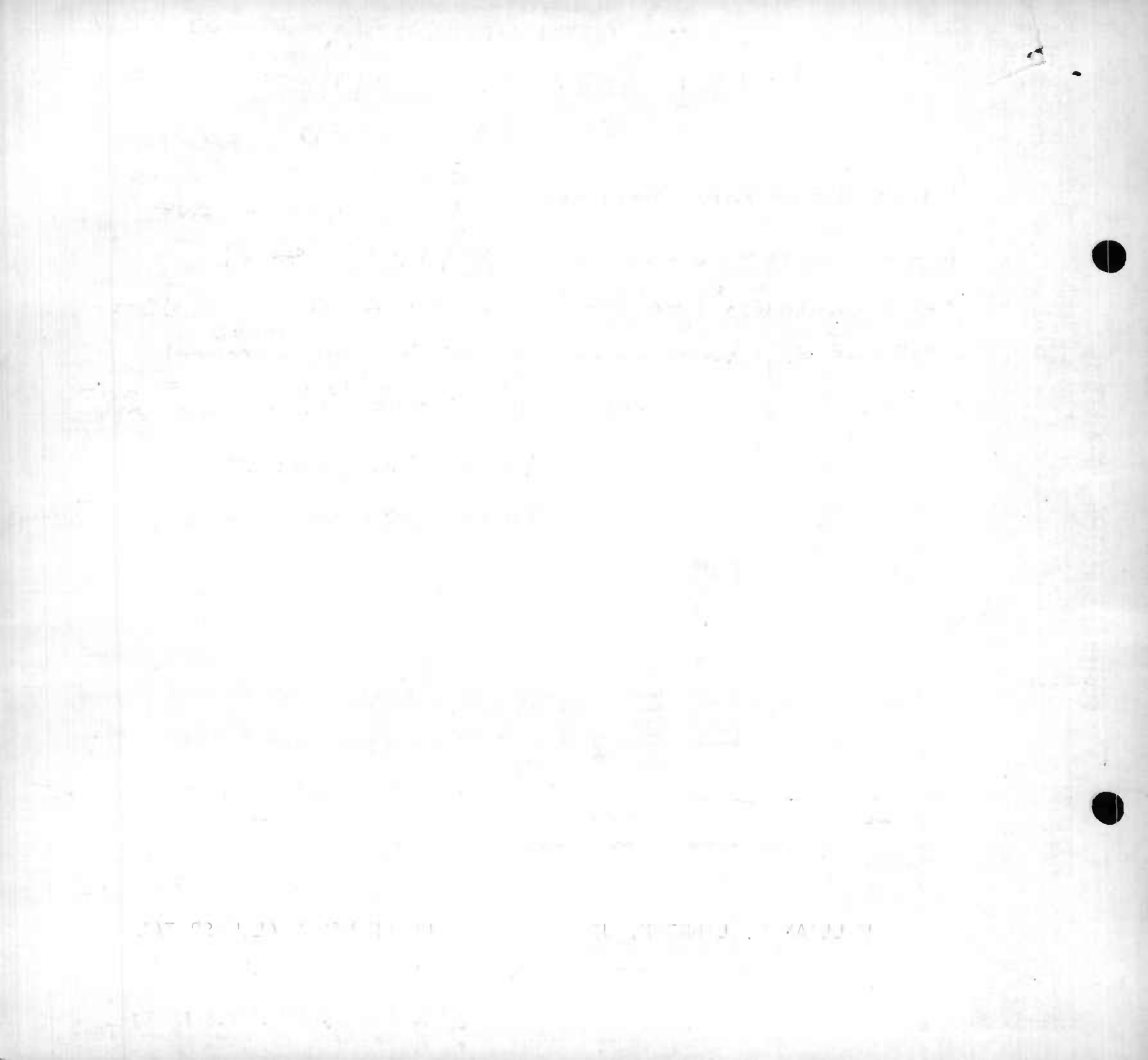
BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 65 8246					Registered No. 65 8246					
M.E. CASE NO.					2. DATE AND HOUR OF DEATH					
1. NAME OF DECEASED (Type or Print) IDA (ADA) SPIVAK					AUGUST 7, 1965 <i>about 3 a.m.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY					
5351 GIST AVENUE					MARYLAND					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
					BALTIMORE					
					D. STREET ADDRESS (If rural, give location)					
					5351 GIST AVENUE					
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		
FEMALE		WHITE		WIDOWED				85		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE			AT HOME			RUSSIA			USA	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME				
UNKNOWN						UNKNOWN				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
NO				NO		MRS. SYLVIA SILVERMAN 5351 GIST AVENUE				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH						CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)						Acute Coronary Thrombosis: sudden				
ANTECEDENT CAUSES						(A) DUE TO				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(B) DUE TO		10 years		
						(C) DUE TO				
II						Diabetes Mellitus		35 years		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0										
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?				
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 5/10/59 to 8/7/65 that (I) (we) last saw the deceased alive on 6/24/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED		
DR. JULIUS GLUCK								8/7/65		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS							
			5356 REISTERSTOWN RD.							
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
BURIAL			8/8/65		SHOMREI MISHMERES		ROSEDALE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS				
AUG 9 1965 Robert E. Levinson			9650007759			SOI LEVINSON & BROS. INC. 6010 REISTERSTOWN RD.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

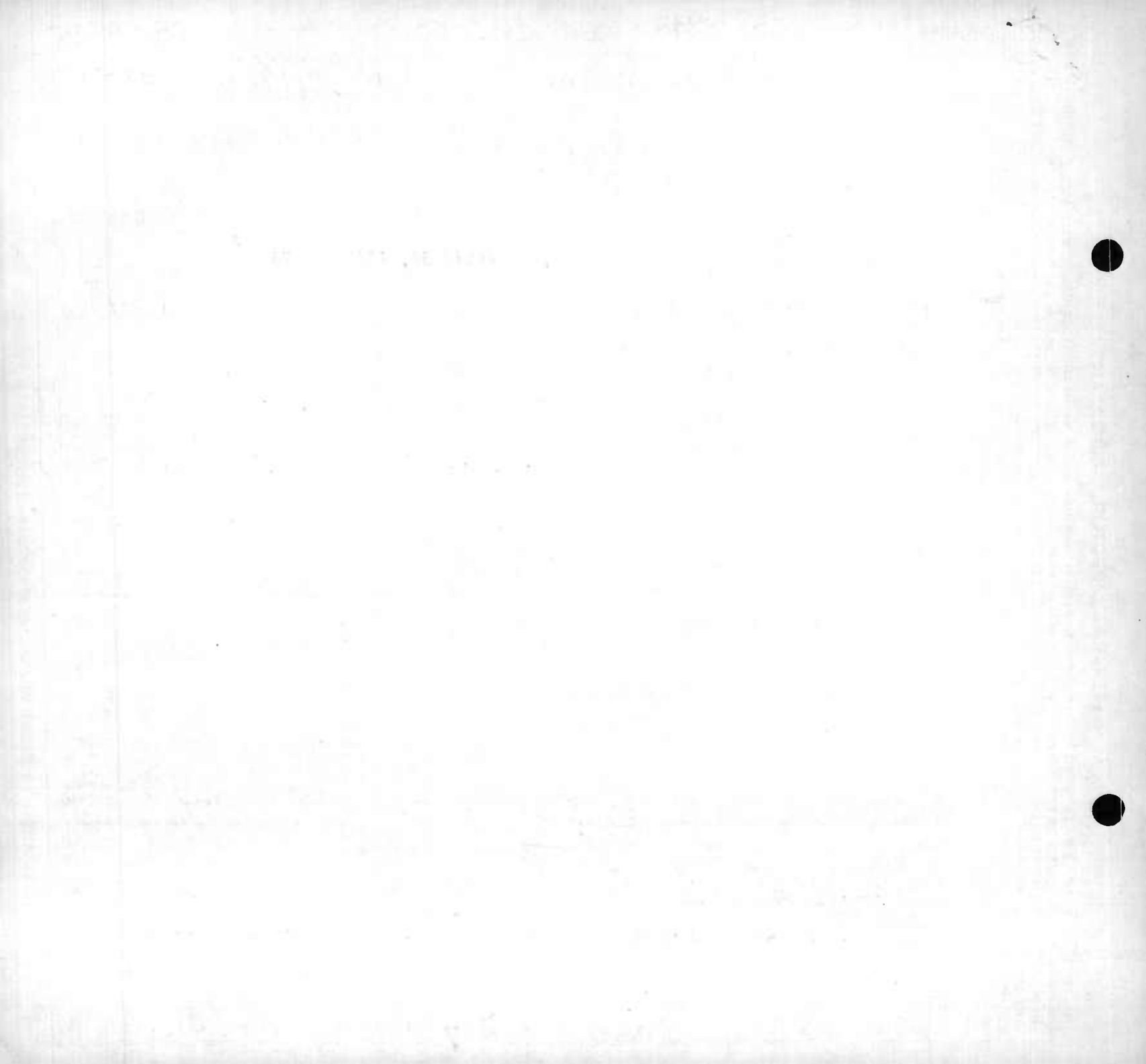
BIRTH NO. 65 8247		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 8247	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) HARRY SETZER		2. DATE AND HOUR OF DEATH 8/7/65 3:05 am			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 9109 YVONNE AVE			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10/7/15	9. AGE (In years last birthday) 50	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ISAAC SETZER (father?)		14. MOTHER'S MAIDEN NAME ROSE (MAMA)		12. CITIZEN OF WHAT COUNTRY? USA.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 1048		17. INFORMANT ROSALE	
18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory Arrest		CAUSE OF DEATH (A) OUE TO Respiratory Arrest (B) OUE TO Cerebral Vascular Hemorrhage 8 days (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 8/1 19 65 to 8/7 19 65 , that (I) was last saw the deceased alive on 8/7 19 65 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.					
23A. SIGNATURE William R. Linton, Jr		M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/7/65	
23C. PHYSICIAN'S NAME (Type) WILLIAM R. LINTON, JR		23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/9/65		24C. NAME OF CEMETERY or CREMATORY BETH HAMEDROSH HAGODOL	
24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REIS		ADDRESS TERS UN RD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 8248		CERTIFICATE OF DEATH		65 8248	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		Bessie Simon		Aug 8, 1965 3:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
House in the City Belvedere Nursing Home W. Belvedere Ave		Maryland 27-19			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
Female		White		Widow	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Housewife		at Home		April 30, 1889	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
Hyman Balber		Anna		76	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY?	
				USA	
17. INFORMANT		ADDRESS			
Mrs Belle Gordon		5829 Jorgue Avenue			
18. 420.01		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Anteroseptotic Heart Disease		Seven yrs	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(B) Generalized Arteriosclerosis		Seven yrs	
ANTECEDENT CAUSES		(C)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 2 1965 to Aug 8 1965, that (I) (we) last saw the deceased alive on Aug 8 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Donald H. Dembo				Aug 9, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
DONALD H. DEMBO		827 LINDEN AVE. 21201			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/9/65		Chesapeake Amund	
24D. LOCATION (City, town, or county) (State)		24E. NAME OF REGISTRAR		24F. FUNERAL DIRECTOR	
Baltimore, Md		Robert E. Fadden		Sally Johnson	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 9 1965		Robert E. Fadden		Sally Johnson	
				ADDRESS	
				6610 Rust Road	



1
c-652

65 8249

BALTIMORE CITY HEALTH DEPARTMENT

65 8249

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
GEORGE CERNICK Cernik		8/6/65 3:48 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland	
City Hospitals		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 1101 Steelton Ave.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
male	white	married	6-5-1902
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday)	11. BIRTHPLACE (State or foreign country)
Patrolman	Balto. City Police	63	Baltimore
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	12. CITIZEN OF WHAT COUNTRY?	
James Cernik	Mae Dumphy	U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		Mildred Cernik	1101 Steelton Ave
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		yes	yes
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
	WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Werner H. Spitz, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	
Burial		8-9-65	
23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Baltimore Cemetery		Baltimore Maryland	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR	
AUG 9 1965		Robert E. Farber, M.D.	
24C. FUNERAL DIRECTOR		ADDRESS	
Walter Dabrowski		1005 Dundalk Ave	

VS 151-REV. 1/1/65

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WALLISY PROFILE

CONTENTS

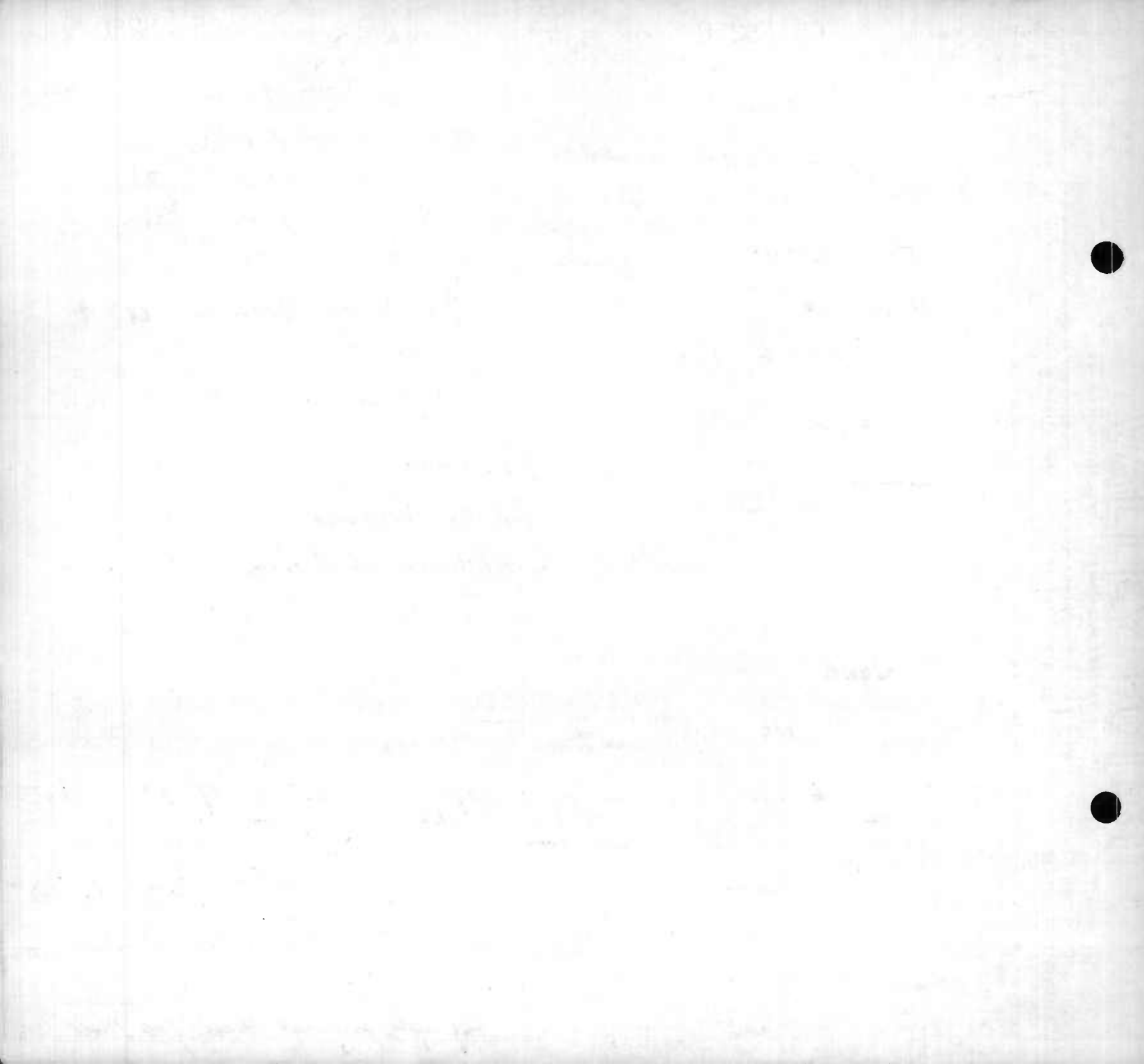
1. Introduction

2. Summary

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8250		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8250	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) KATIE THON			2. DATE AND HOUR OF DEATH Aug 7, 1965 7:02 AM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSP. - BALTO., MD.			A. STATE MARYLAND B. COUNTY Baltimore		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21 53-00		
			D. STREET ADDRESS (If rural, give location) 9 S. STUART ST.		
5. SEX F	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 6/11/93	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME MICHAEL KAISER			14. MOTHER'S MAIDEN NAME LENA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Jensen, MD. GEN'L Hosp		
18. 3-81-01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) UREMIA DUE TO (B) RENAL FAILURE DUE TO (C) CIRRHOSIS OF LIVER		INTERVAL BETWEEN ONSET AND DEATH 36 hrs. 48 hrs. 2 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 8/3 1965 to 8/7 1965, that (I) lost saw the deceased alive on 8/7 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE Jensen, M.D.			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Aug 7, 1965
23C. PHYSICIAN'S NAME (Type) LOUIS O. OLSEN, MD.			23D. ADDRESS MARYLAND GENERAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/10/65	24C. NAME OF CEMETERY or CREMATORY Oak Lawn		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Carmelly Funeral Home - 300 More Ave	



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No.	
65 8251						65 8251	
M.E. CASE NO.				1. NAME OF DECEASED			
				SPARKS, IDANA.			
2. DATE AND HOUR OF DEATH				8/7/65 1 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
University Hospital				Va TAGAWAL Cedar Bluff Rt. 1.			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				Cedar Bluff			
D. STREET ADDRESS (If rural, give location)				Rt. 1.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
F.	W.	Married	10/26/25	39			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		-		VA.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		17. INFORMANT		ADDRESS	
Unknown		Alice Southerland		Hospital chart			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
-		-		Hospital chart			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		1 1/2 year.	
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
7/28/65		Fair/Rectovaginal fistula		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
-		-		-			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
-		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		-			
22. I certify that (this hospital) attended the deceased from 7/9/65 to 8/7/65							
that (we) last saw the deceased alive on 8/7/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
A. Joffe, M.D.						8/7/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
ALI-LOTFI				University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Aug. 10-65		Sparks Cemetery		Cedar Bluff Va.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 9 1965		Robert E. Taylor		John J. Connelly		Essex 21, Md.	

25/1/12 25/1/12

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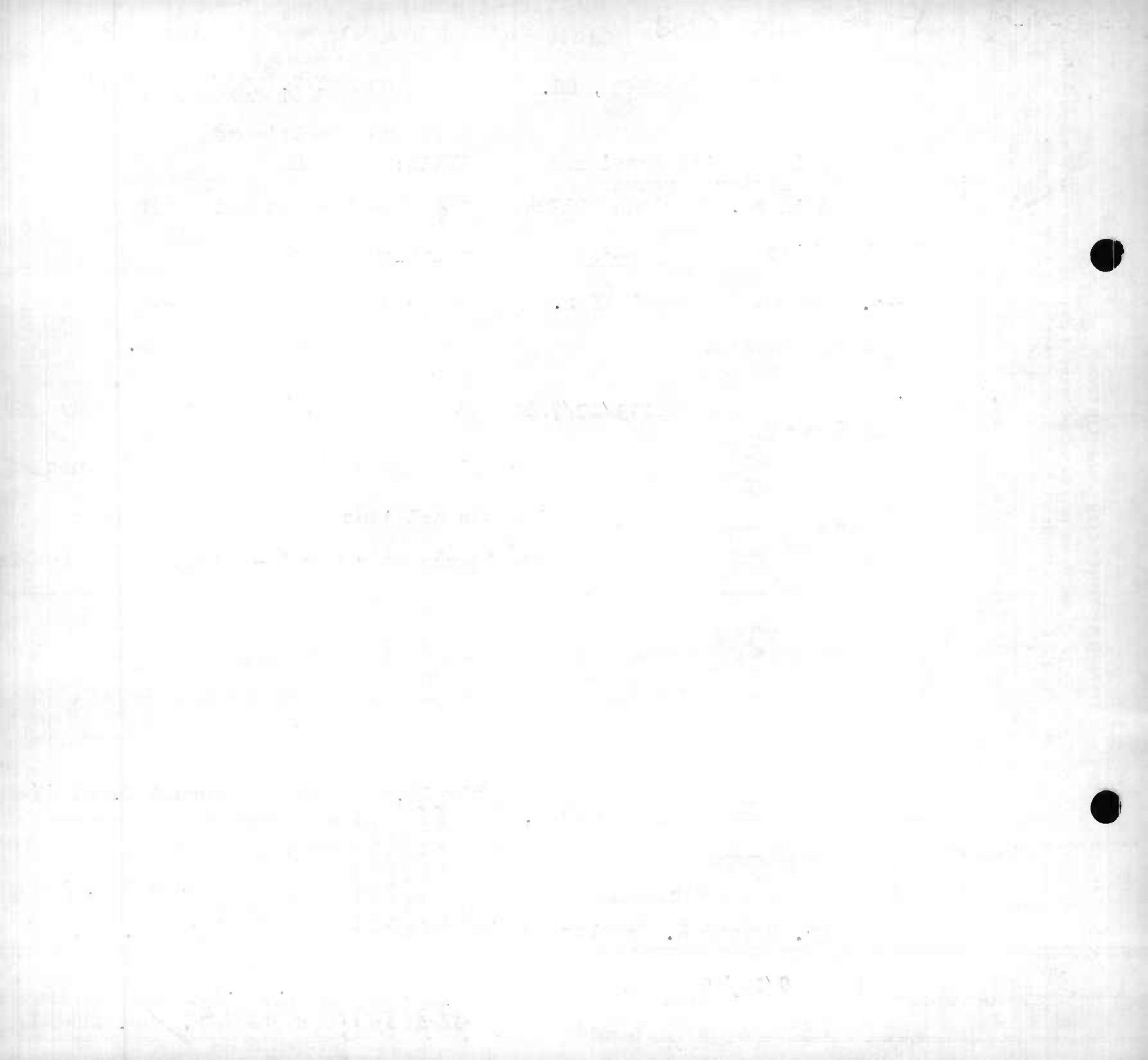
25/1/12 25/1/12

LS: 43-04-04

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 8-362 65 8252		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 8252	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Steve Peterka, SR.				2. DATE AND HOUR OF DEATH August 7, 1965 11:10 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) RURAL : DUNDALK D. STREET ADDRESS (If rural, give location) 203 Cleveland XXXXX AVENUE #21222			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12-12-97	9. AGE (In years last birthday) 67	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen. Foreman		10B. KIND OF BUSINESS OR INDUSTRY Steel Mfrg.		11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME STEVE PETERKA				14. MOTHER'S MAIDEN NAME THERESA (LAST NAME UNK.)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213/07/7089		17. INFORMANT ADDRESS RECORDS: BCH: 4940 Eastern Avenue #24			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction				INTERVAL BETWEEN ONSET AND DEATH 48 Hours			
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes Mellitus				Years			
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Cardio-Vascular Disease				Years			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 18, 1965 to August 7, 1965 , that (I) (we) last saw the deceased alive on August 7, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 7, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. Howard K. Rathbun				23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. #24			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/11/65		24C. NAME of CEMETERY or CREMATORY OAK LAWN		24D. LOCATION (City, town, or county) (State) BALTO. CO. MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR WALTER BROOKS BRADLEY, INC.		25C. FUNERAL DIRECTOR'S ADDRESS DUNDALK			



CERTIFICATE OF DEATH

Registered No. 65 8253

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Margie A. Davis

2. DATE AND HOUR OF DEATH

8-5-1965 12.35 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1704 Ramsay Street 21223

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

8-8-1893

9. AGE (In years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ulysses Watson

14. MOTHER'S MAIDEN NAME

Mabel Johnson

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

220-14-5929

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18. 170X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Carcinoma of (L) Breast

INTERVAL BETWEEN
ONSET AND DEATH

1 1/2 months

(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)(A)
DUE TO

ANTECEDENT CAUSES

(B)
DUE TODISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At
Work ☐Not While
At Work ☐22. I certify that (I) (this hospital) attended the deceased from 6-28-1965 to 8-5-1965.
that (I) (we) last saw the deceased alive on 8-5-1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☐Med.
Director ☐Stoll
Phys. ☒

23B. DATE SIGNED

8-5-1965

23C. PHYSICIAN'S
NAME (Type)

Dr. Donald Baltzan

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/9/65

24C. NAME OF CEMETERY or CREMATORY

Loudon Park Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 9 1965

25B. NAME OF REGISTRAR

R. L. E. F. F. F.

25C. FUNERAL DIRECTOR

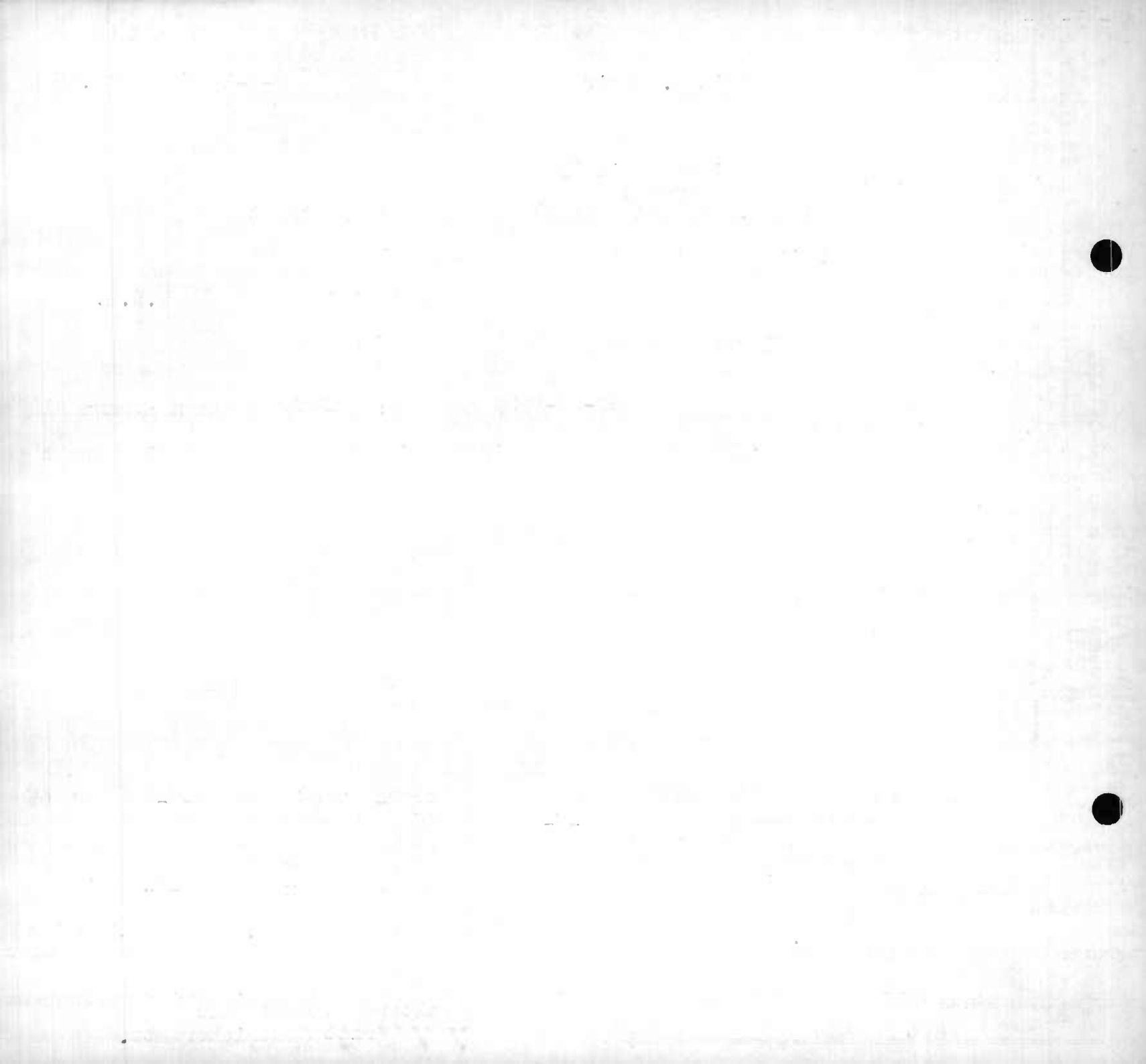
Walters Funeral Home

ADDRESS

77 Pratt & Stricker Sts.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 8254</u>	
BIRTH NO. <u>65 8254</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type at Print) <u>Hasselhoff, Mabel A.</u>		2. DATE AND HOUR OF DEATH <u>August 6 1965</u> <u>6.08P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>St. Josephs Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 21231</u> D. STREET ADDRESS (If rural, give location) <u>1831 E. Lombard St.</u>			
5. SEX <u>female</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>widowed</u>	8. DATE OF BIRTH <u>7-8-1893</u>	9. AGE (In years last birthday) <u>72yrs.</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>John Taylor</u>		14. MOTHER'S MAIDEN NAME <u>SARAH Unk</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Selmar C. Hasselhoff 1831 E Lombard St.</u>	
18. <u>174X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary Embolism</u> DUE TO (B) <u>Abdominal Carcinomatosis</u> DUE TO (C) <u>Advanced Ca of uterus</u>		INTERVAL BETWEEN ONSET AND DEATH			
19. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>August 6</u> 19 <u>65</u> to <u>August 6</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>August 6</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Licerio Cerna</u> M.D.				23B. DATE SIGNED <u>August 6 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>Licerio Cerna</u>		23D. ADDRESS M.D. <u>1400 N. Caroline St. Baltimore 21213 Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Aug 9 1965</u>		24C. NAME of CEMETERY or CREMATORY <u>First United Evangelical Cem</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto, Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 9 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fickel</u>		25C. FUNERAL DIRECTOR <u>The Dippel Bros Inc. 1800 E Lombard St</u>			

U.S.A.

Baltimore, Md.

SAVER 195

John Taylor

Belmont & Harbo, 107 N. 1st - Baltimore, Md.

1955

10

Journal of the

Journal of the American Society of Tropical Medicine and Hygiene, Vol. 10, No. 1, 1955

The Journal of the American Society of Tropical Medicine and Hygiene, Vol. 10, No. 1, 1955

FUNERAL DIRECTOR: IMPORTANT

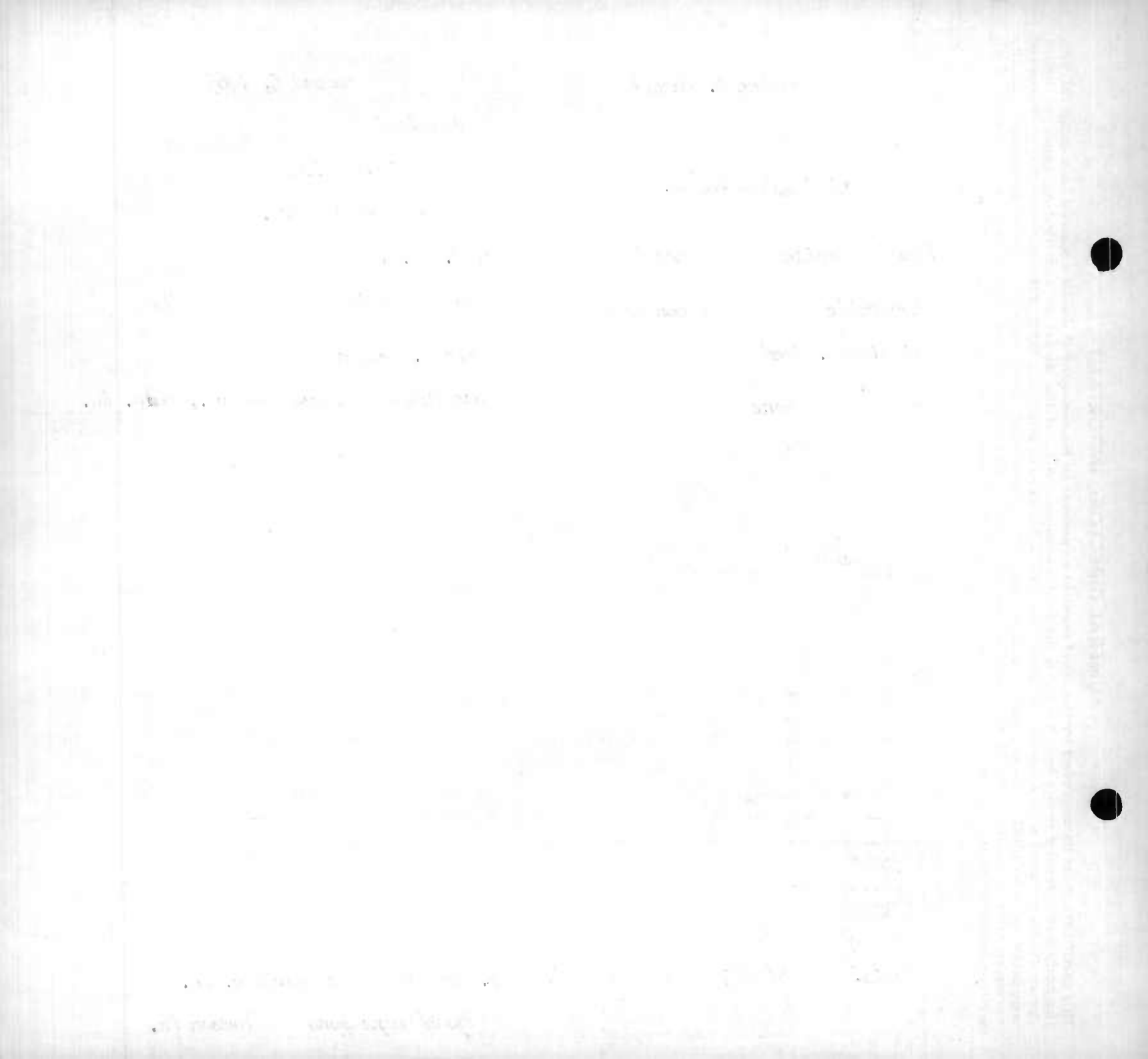
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 8255					CERTIFICATE OF DEATH				
Registered No. 65 8255									
1. NAME OF DECEASED (Type or Print) SISTER MARY VERONICA (Mary S. Morris)					2. DATE AND HOUR OF DEATH 8-7-1965 4:00 P. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 20-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 301 N. CALVERTON RD.				
5. SEX FEMALE	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH Dec. 20, 1886	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Religious			10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Francis P. Morris					14. MOTHER'S MAIDEN NAME MARY E. Adams				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS Convent Records 301 N. Calverton Rd.				
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Acute Myocardial Infarction DUE TO (B) atherosclerotic Cardiovascular Disease DUE TO (C) atherosclerotic Cardiovascular Disease					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 8-6-1965			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 8-6-1965 19 8-7- 19 65 , that (I) (we) last saw the deceased alive on 8-7- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
23A. SIGNATURE Joseph Notarangelo					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 8-7-1965	
23C. PHYSICIAN'S NAME (Type) JOSEPH NOTARANGELO					23D. ADDRESS MERCY HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-10-65		24C. NAME of CEMETERY or CREMATORY NEW CATHEDRAL		24D. LOCATION (City, town, or county) (State) BALTIMORE MD			
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965			25B. NAME OF REGISTRAR Paul E. Taylor			25C. FUNERAL DIRECTOR'S NAME AND ADDRESS Funeral Home 2101 Broadway Ave. CECIL SQUARE FUNERAL HOME			

FUNERAL DIRECTOR: IMPORTANT

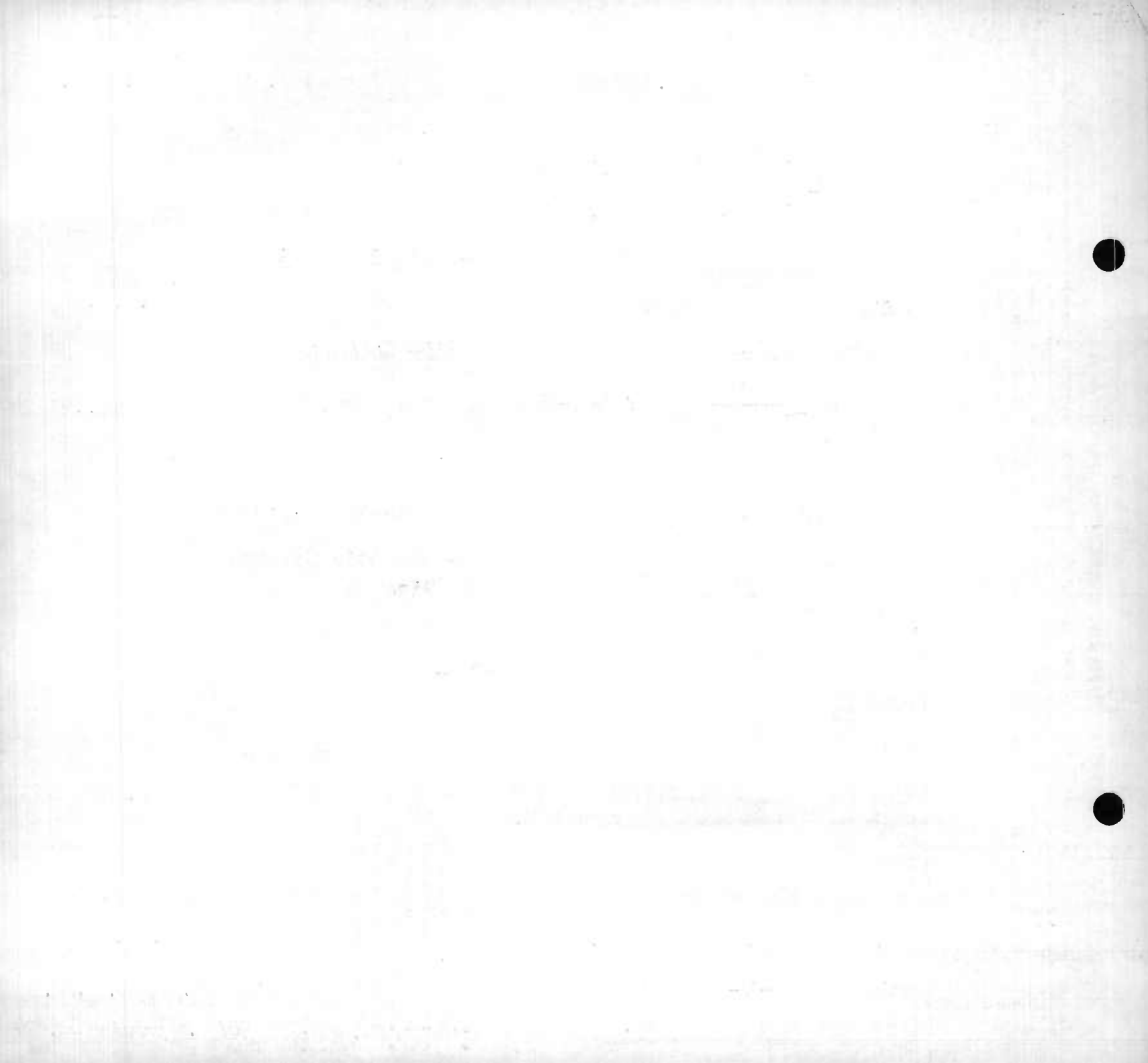
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8256				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8256			
M.E. CASE NO.				CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH							
Jestine M. Burget				August 5, 1965				1:30 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE				B. COUNTY			
(If not in hospital or institution, give street address or location)				Maryland				27-12			
304 Evesham Avenue				C. CITY OR TOWN (If outside city limits, write RURAL and give township)				Baltimore 21212			
				D. STREET ADDRESS (If rural, give location)				304 Evesham Ave.			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)		10. If Under 1 Yr. Months Days	
Female		white		married		Sept. 23, 1897		67			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
housewife				own home				Pennsylvania			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
William B. Reed				Anna B. Welkef				USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
no				none				John Burget 304 Evesham Ave., Balto. Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO				2 Yrs			
ANTECEDENT CAUSES				(B) DUE TO				13+ yrs			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)							
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
O				No							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from Feb 5 1962 to Aug 5 1965, that (I) (we) last saw the deceased alive on Aug 5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
Frederick J. Vollmer				8/7/65							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
FREDERICK J VOLLMER				6100 YORK RD BALTIMORE-MD 21212							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
Burial		8/9/65		Dulaney Valley Mem. Gardens		Cockeysville, Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
AUG 9 1965		Robert E. Taylor		John Burns Sons		Towson Md.					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

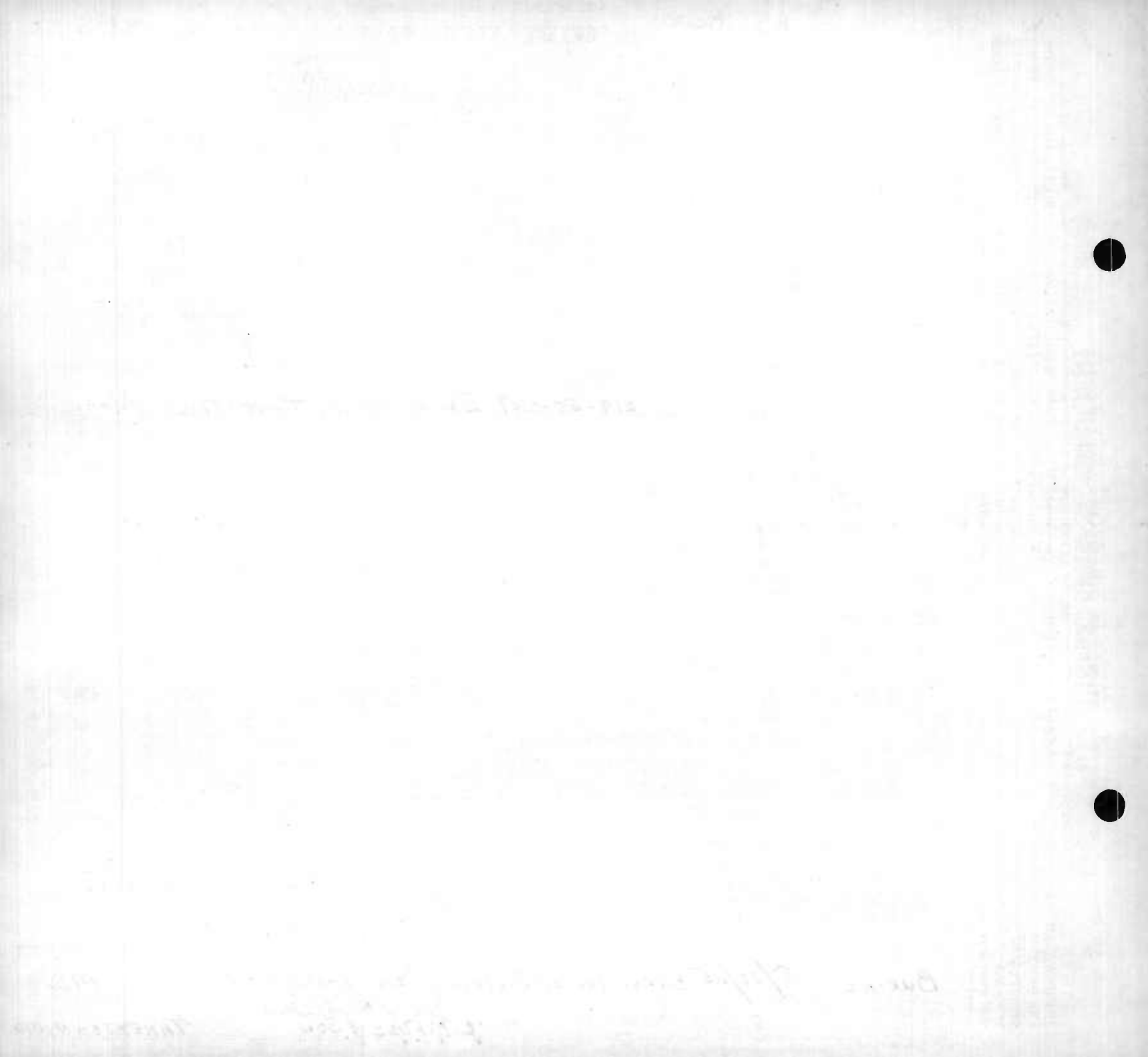
BIRTH NO. 261 8257				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 8257	
1. NAME OF DECEASED (Type or Print) John Joseph Cosgrove				2. DATE AND HOUR OF DEATH August 7, 1965 9:40 A. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland, #21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-34 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 935 Spangler Way, #21205					
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 1-29-1892	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Rheems Company		11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Cosgrove				14. MOTHER'S MAIDEN NAME Ellen Gillespie					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 191-09-6384		17. INFORMANT ADDRESS RECORDS: BCH, 4940 Eastern Ave., 21224					
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia				CAUSE OF DEATH (A) DUE TO Pneumonia				INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebro Vascular Accident				(B) DUE TO Arterio-Sclerotic Cerebral					
				(C) Vascular Disease					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from March 30, 1965 to August 7, 1965 , that (I) (we) last saw the deceased alive on August 7, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Howard K. Rathbun				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 7, 1965			
23C. PHYSICIAN'S NAME (Type) DR. HOWARD K. RATHBUN				23D. ADDRESS M.D. 4940 Eastern Avenue, Balto, Md., #21224					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-11-65		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) 7225 Eastern Blvd. Balto, Md., #21224			
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Chapman & Jailer 901 S. Conkling St. #24					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

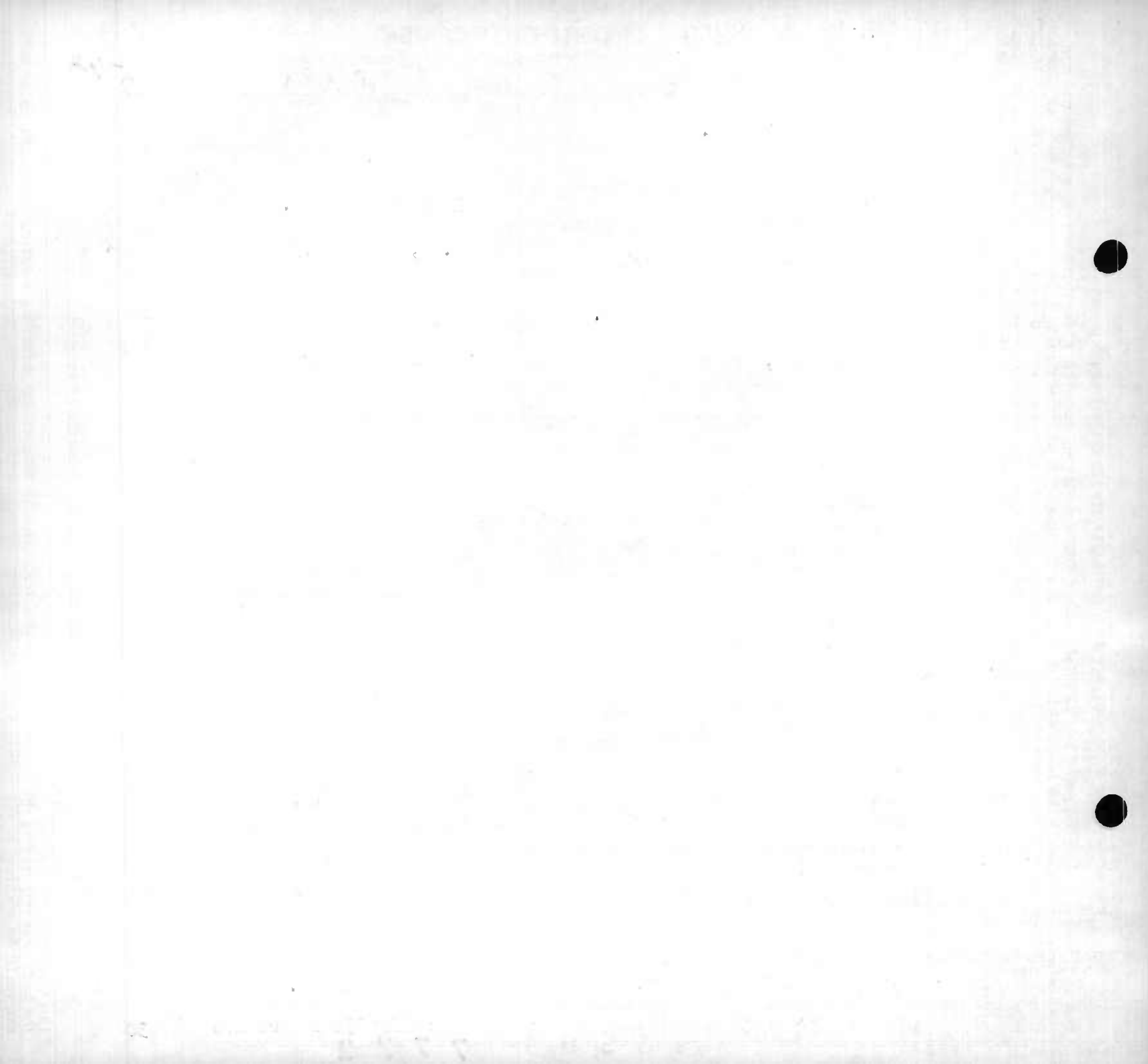
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8258	
BIRTH NO. 65 8258		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Esther Rietha Hahn</u>		2. DATE AND HOUR OF DEATH <u>Aug 7, 1965</u> <u>10⁰⁰</u> <u>PM.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Council</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u> <u>Baltimore, Md.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Taneytown</u> <u>56-00</u>			
		D. STREET ADDRESS (If rural, give location) <u>Box 284</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>9-23-98</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Samuel Ridinger</u>		14. MOTHER'S MAIDEN NAME <u>Mary S. Hines</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-05-0107</u>		17. INFORMANT <u>EMORY HAHN, TANEYTOWN, MARYLAND</u>	
18. <u>332X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Broncho pneumonia</u> DUE TO (B) <u>Basilar 2 Post Cerebellar Art Thrombosis</u> DUE TO (C) <u>Cerebral Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>15 days</u> <u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>7-15-65</u> 19 to <u>8-7-65</u> 19, that (I) (we) last saw the deceased alive on <u>8-7-65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John C. Hisley, M.D.</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8-7-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>John C. Hisley</u>		23D. ADDRESS <u>University Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/10/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>EVAN. UNITED BRETHREN CEM.</u>	
				24D. LOCATION (City, town, or county) (State) <u>TANEYTOWN MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 9 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>John H. Spiller</u> <u>F. J. FUSSELL SON</u>	
				ADDRESS <u>TANEYTOWN, MD.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

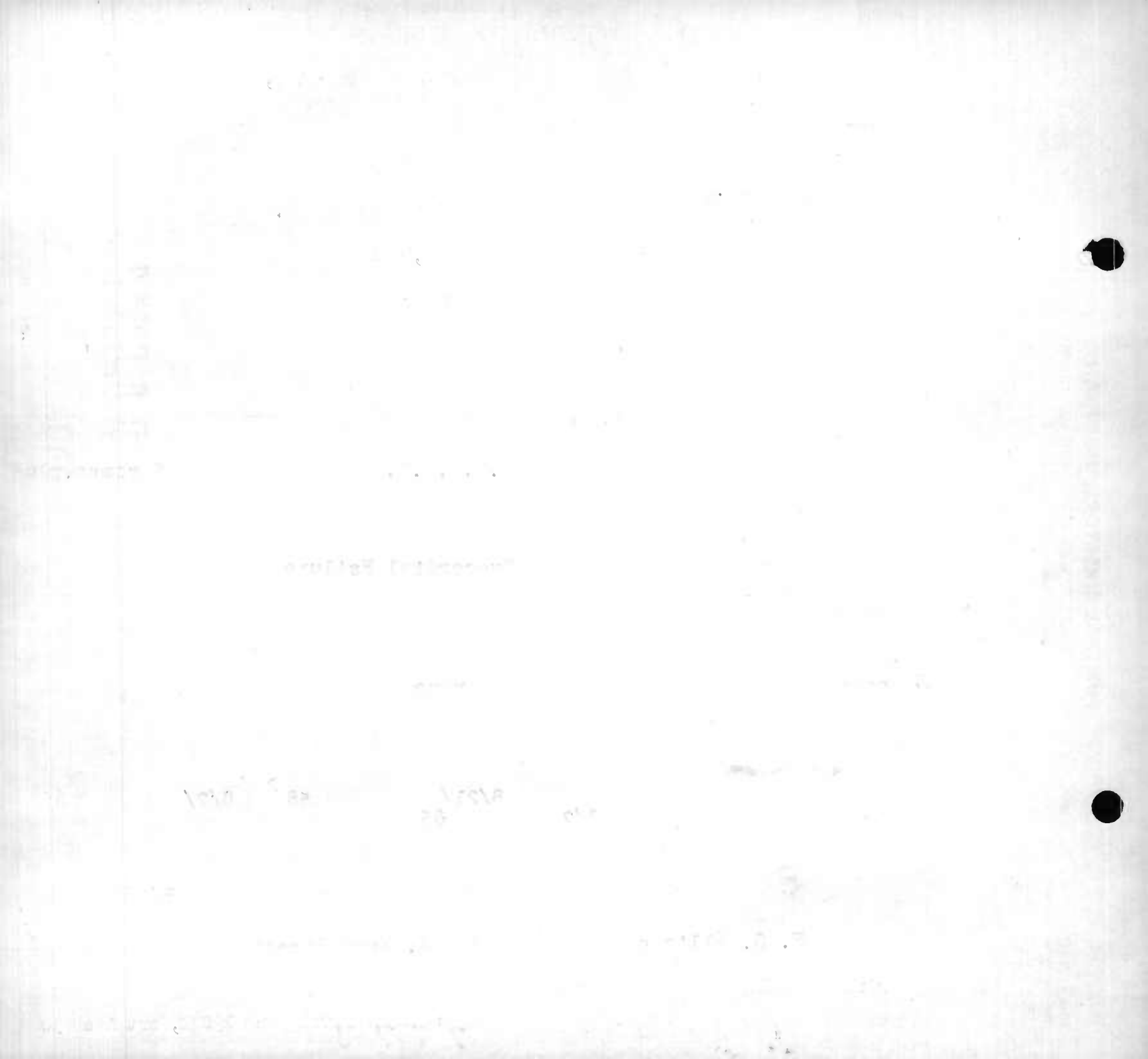
BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 65 8259					CERTIFICATE OF DEATH					
M.E. CASE NO. 65 8259					Registered No. 65 8259					
1. NAME OF DECEASED (Type or Print) <i>John F. Porter Sr.</i>					2. DATE AND HOUR OF DEATH <i>8/7/65</i> <i>5:42 P. M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <i>So. Balto. Gen. Hosp.</i> (If not in hospital, give address or location)					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>23-02</i>					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>					
					D. STREET ADDRESS (If rural, give location) <i>1741 Clarkson St.</i>					
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>Mar. 14, 1900</i>	9. AGE (In years last birthday) <i>65</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Gen. Elect.</i>		11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>John F. Porter</i>					14. MOTHER'S MAIDEN NAME <i>Catherine Palmer</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Same</i>			ADDRESS			
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Myocardial Infarction</i> ANTECEDENT CAUSES <i>Atherosclerosis</i> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION <i>0</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from <i>8-7-</i> <i>19 65</i> to <i>8-7-</i> <i>19 65</i> , that (I) (we) last saw the deceased alive on <i>8-7-</i> <i>19 65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <i>Kenneth P. Bonovich</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8-8-65</i>			
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8 11 65</i>		24C. NAME of CEMETERY or CREMATORY <i>Glen Haven Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>AA Co. Md</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 9 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor M.D.</i>		25C. FUNERAL DIRECTOR <i>McCully 130 E Fort Ave</i>		ADDRESS <i>360</i>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8260
BIRTH NO. 65 8260		CERTIFICATE OF DEATH		
M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Catherine Lang		2. DATE AND HOUR OF DEATH August 7, 1965 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION S.B.G.H.		A. STATE Md B. COUNTY 24-04		
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
		D. STREET ADDRESS (If rural, give location) 1632 Jackson St.		
5. SEX Female	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Jan 29, 1882	9. AGE (In years - last birthday) 83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hungary
12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Unk		14. MOTHER'S MAIDEN NAME Unk		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Same
18. 4 22 11		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) A.S.C.V.D.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		
		(C) Myocardial Failure		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH 5 years, plus		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) none
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 0 none		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 8/21/ 19 58 to 8/7/ 19 65 , that (I) was lost saw the deceased alive on 8/7 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE 		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/9/65
23C. PHYSICIAN'S NAME (Type) E. S. Ellison		23D. ADDRESS M.D. 107 E. West Street		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/12/65	24C. NAME of CEMETERY or CREMATORY Holy Cross		24D. LOCATION (City, town, or county) (State) AA Co Md
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR McCully Funeral Home
				ADDRESS 130 E, Fort Ave 30



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 8261	
1. NAME OF DECEASED (Type or Print) Norman Watts				2. DATE AND HOUR OF DEATH 8/6/65 11:35A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 Church Home Hospital				4. USUAL RESIDENCE Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY aa C. CITY OR TOWN (If outside city limits, write RURAL and give township) Hanover 32-00 D. STREET ADDRESS (If rural, give location) At 2 Box 175			
5. SEX M	6. RACE Cau	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 5-14-96	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sign painter		10B. KIND OF BUSINESS OR INDUSTRY US government		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Watts				14. MOTHER'S MAIDEN NAME Elizabeth Broadbridge			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWI		16. SOCIAL SECURITY NO. 215-16-1934		17. INFORMANT ADDRESS Catherine Watts, Hanover Md.			
B. 182.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) Bronchogenic Carcinoma DUE TO		INTERVAL BETWEEN ONSET AND DEATH - 2 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Ureteral stricture							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-14 19 65 to 8-6 19 65 , that (I) (we) last saw the deceased alive on 8-6 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ephraim B. Barzaga M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 8-6-65			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS EPHRAIM B. BARZAGA M.D. CHURCH HOME & HOSPITAL - BALTO. 31 MD.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8-9-65		24C. NAME OF CEMETERY OR CREMATORY Madamridge Memorial Park, Darnestown, Md.		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert S. [illegible]		25C. FUNERAL DIRECTOR DeWitts, Daniel, Laurel Md.		ADDRESS	

8/6/82

Handwritten

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Church Home Hospital

Can

Handwritten

8/14/82

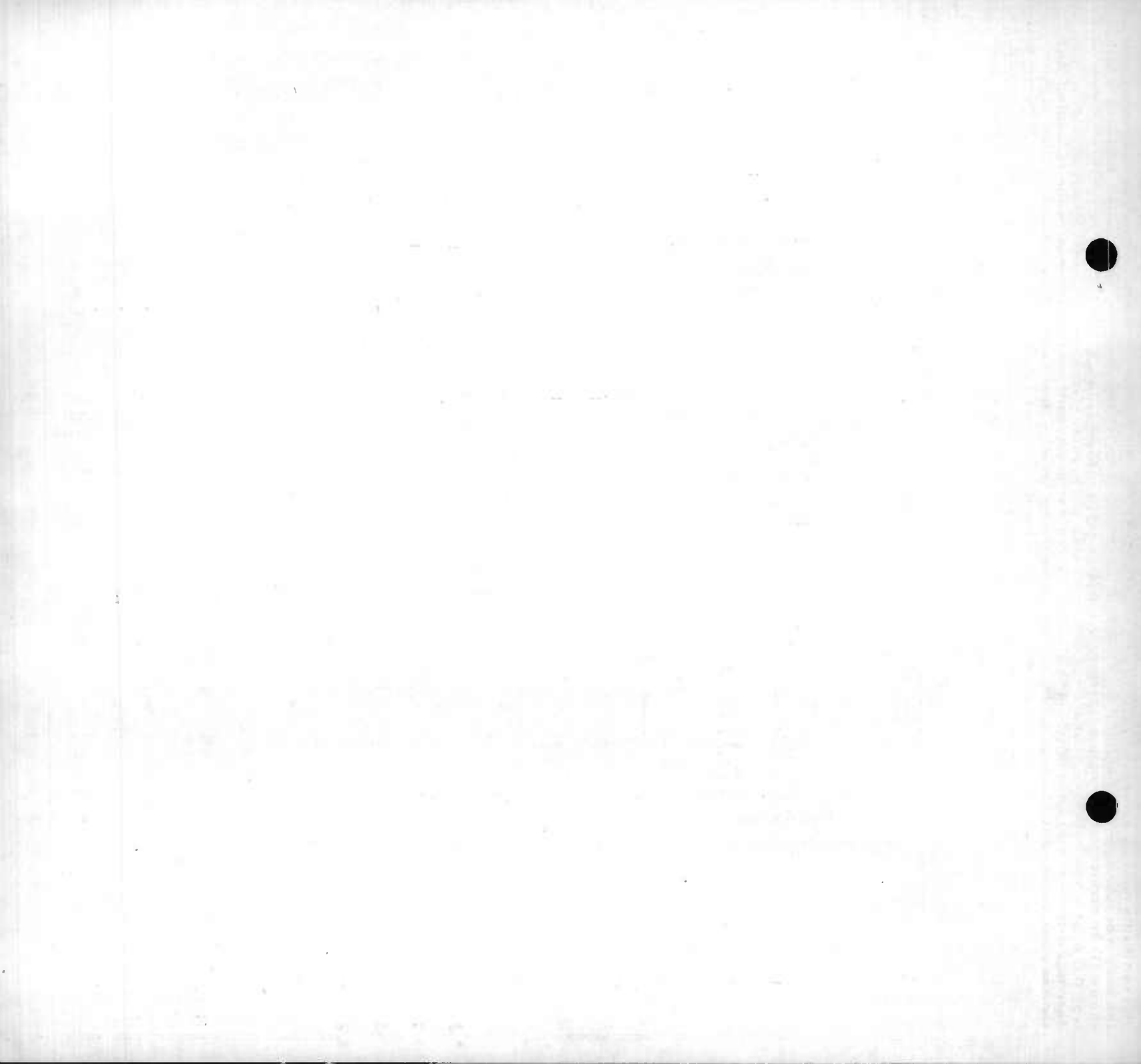
Branch Home Hospital

Handwritten

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8262	
BIRTH NO. 65 8262		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Isabelle J. Roe		2. DATE AND HOUR OF DEATH August 8, 1965 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BAR WIL-BA CONVALESCENT 2101 W. Cold Spring Lane		D. STREET ADDRESS (If rural, give location) 825 Newington Avenue			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Oct-12-1893	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Winnsbora, South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Johnson		14. MOTHER'S MAIDEN NAME Louise Simmons	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 215-12-0998		17. INFORMANT Mrs. Jannie Gaston 825 Newington Ave	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Coronary Disease DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 wks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1 1965 to Aug 8 1965, that (I) (we) last saw the deceased alive on Aug 6 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis A. Johnson M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Louis A. Johnson M.D.		23D. ADDRESS 301 - E - 22 St. Bldg. 18th fl.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-13-65		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION (City, town, or county) Arbutus, Maryland		24E. DATE REC'D BY HEALTH DEPT. AUG 9 1965		24F. NAME OF REGISTRAR Robert E. Taylor	
24G. FUNERAL DIRECTOR Morton and Dyett Funeral Home		24H. ADDRESS		24I. 777 E	



BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 8263

1. NAME OF DECEASED
(Type or Print)

ANDREW JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

August 6, 1965

10:50 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1325 N. Fulton Avenue

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

July 14, 1903

9. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Pipe-fitter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Charles County, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Moses Washington

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Margaret Johnson 1325 N. Fulton Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenecker

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-6-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Aug-10-65

23C. NAME of CEMETERY or CREMATORY

Mount Auburn Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 9 1965

The Morton and Dyett
1701-31 Laurens St. 21217

100

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

U.S. G.A.

MAIL ROOM CONTROL
DEPT. OF JUSTICE

MAIL ROOM CONTROL

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

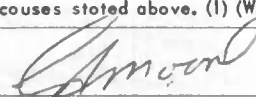
1. NAME OF DECEASED (Type or Print) BLIZZARD, Arianna W.		2. DATE AND HOUR OF DEATH 8.9.65 6:05 A.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY Balto.	
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto	
		D. STREET ADDRESS (If rural, give location) 405 Swann Ave.	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8.20.11
9. AGE (In years last birthday) 54		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Whitehaven, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Wingate		14. MOTHER'S MAIDEN NAME Mary Smith	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Yes	
17. INFORMANT Walter B. Blizzard		ADDRESS 405 Swann Avenue	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction due to coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH 10 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 7 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7.30 19 65 to 8.9 19 65 . that (I) (we) last saw the deceased alive on 8.9 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE A. Narum		23B. DATE SIGNED 8.9.65	
23C. PHYSICIAN'S NAME (Type) A. NARUM		23D. ADDRESS CHURCH & #	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/12/65	
24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Farber	
25C. FUNERAL DIRECTOR Edwards & Armstrong		ADDRESS Edwards & Armstrong 4600 Liberty Heights	

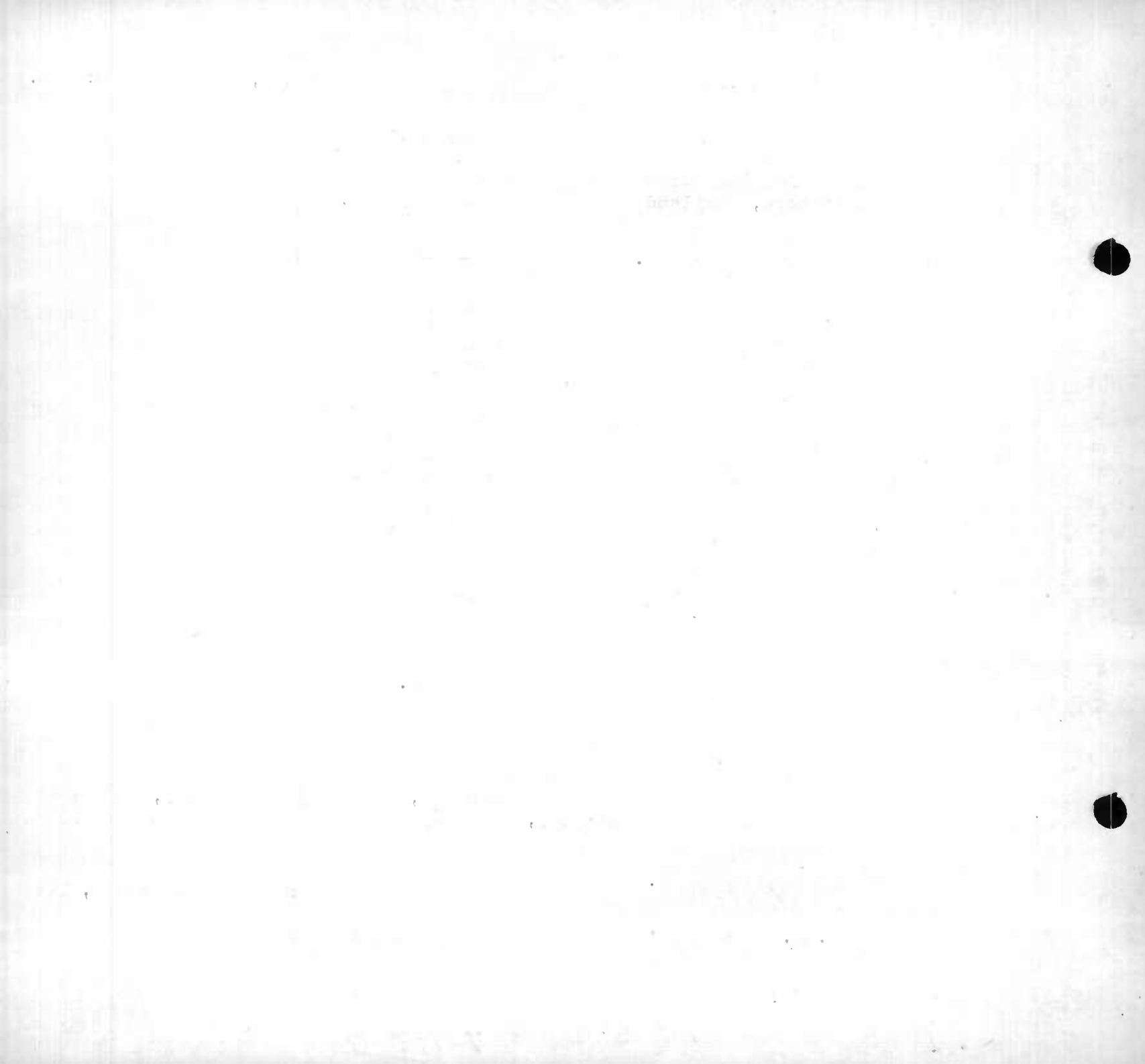
P. Marshall

19. 3. 1984. 24

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8265	
BIRTH NO. 65 8265		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) William Gregory		2. DATE AND HOUR OF DEATH August 7, 1965 10:50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 14-03		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland		D. STREET ADDRESS (If rural, give location) 519 Bloom Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Sep.	8. DATE OF BIRTH 4-12-12	9. AGE (In years last birthday) 54	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel Gregory		14. MOTHER'S MAIDEN NAME Mary	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Marquette Gregory	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CLINICAL IMPRESSION CORONARY THROMBOSIS → OR PULMONARY EMBOLISM		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 5, 1965 to August 7, 1965 , that (I) (we) lost saw the deceased alive on August 7, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. G. H. Moonday		23B. DATE SIGNED August 9, 1965	
23C. PHYSICIAN'S NAME (Type) G. H. Moonday		23D. ADDRESS M.D. 1514 Division Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-11-65		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Baker	
25C. FUNERAL DIRECTOR Agnes E. Baker		ADDRESS 1348 N. Calhoun St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8266		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8266	
1. NAME OF DECEASED (Type or Print) <i>Bailey, Roy L.</i>			2. DATE AND HOUR OF DEATH <i>August 5, 1965 1:15 P. M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Virginia</i> B. COUNTY <i>V-43</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>The Union Memorial Hospital</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Richmond</i>		
(If not in hospital or institution, give street address or location)			D. STREET ADDRESS (If rural, give location) <i>7415 Oakridge St.</i>		
5. SEX <i>Male</i>	6. RACE <i>Caucasian</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>7/12/06</i>	9. AGE (In years last birthday) <i>59</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Watchmaker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Watchmaker</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>American</i>			13. FATHER'S NAME <i>Joseph Bailey</i>		
14. MOTHER'S MAIDEN NAME <i>Stella Enzlish</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unknown</i>		
16. SOCIAL SECURITY NO. <i>33-0900</i>			17. INFORMANT <i>Mrs. Mary Bailey</i> ADDRESS <i>same as above</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of the bladder</i>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>3/2/65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Segmental Resection of Bladder</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (If not at home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <i>July 20</i> 1965 to <i>August 5, 1965</i> , that (we) last saw the deceased alive on <i>August 5</i> 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) view the body after death.					
23A. SIGNATURE <i>A. C. Tipton Jr.</i>				23B. DATE SIGNED <i>August 5, 1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR. A. C. TIPTON, JR.</i>				23D. ADDRESS <i>33rd + Calvert Streets Baltimore, Md. 21218</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-8-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Riverton</i>	
24D. LOCATION (City, town, or county) (State) <i>Riverton Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 9 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Charles W. Marvel & Son</i>			

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED
(Type or Print)

DAISY M. SELBY

2. DATE AND HOUR PRONOUNCED DEAD

August 6, 1965 1:10 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

HOWARD

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Marriottsville - Rural 63-00

D. STREET ADDRESS (If rural, give location)

Sand Hill Road

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Sept. 6, 1889

9. AGE (In years
last birthday)

75

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Andrew Stansfield

14. MOTHER'S MAIDEN NAME

L. MARR

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-07-4383

17. INFORMANT

ADDRESS

Mr. A. Wallace Selby - Marriottsville, Md.

18. E 816.41

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple traumatic injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

U. S. 40 and Sandhill Road 63-00

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour) (P.M.)

8 5 65 10:20 P.M.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

X

21F. HOW DID INJURY OCCUR?

Passenger in auto-auto collision

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breiteneker

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-6-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-9-65

23C. NAME OF CEMETERY or CREMATORY

Mt. View Cemetery

23D. LOCATION

(City, town, or county)

Howard Co.

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

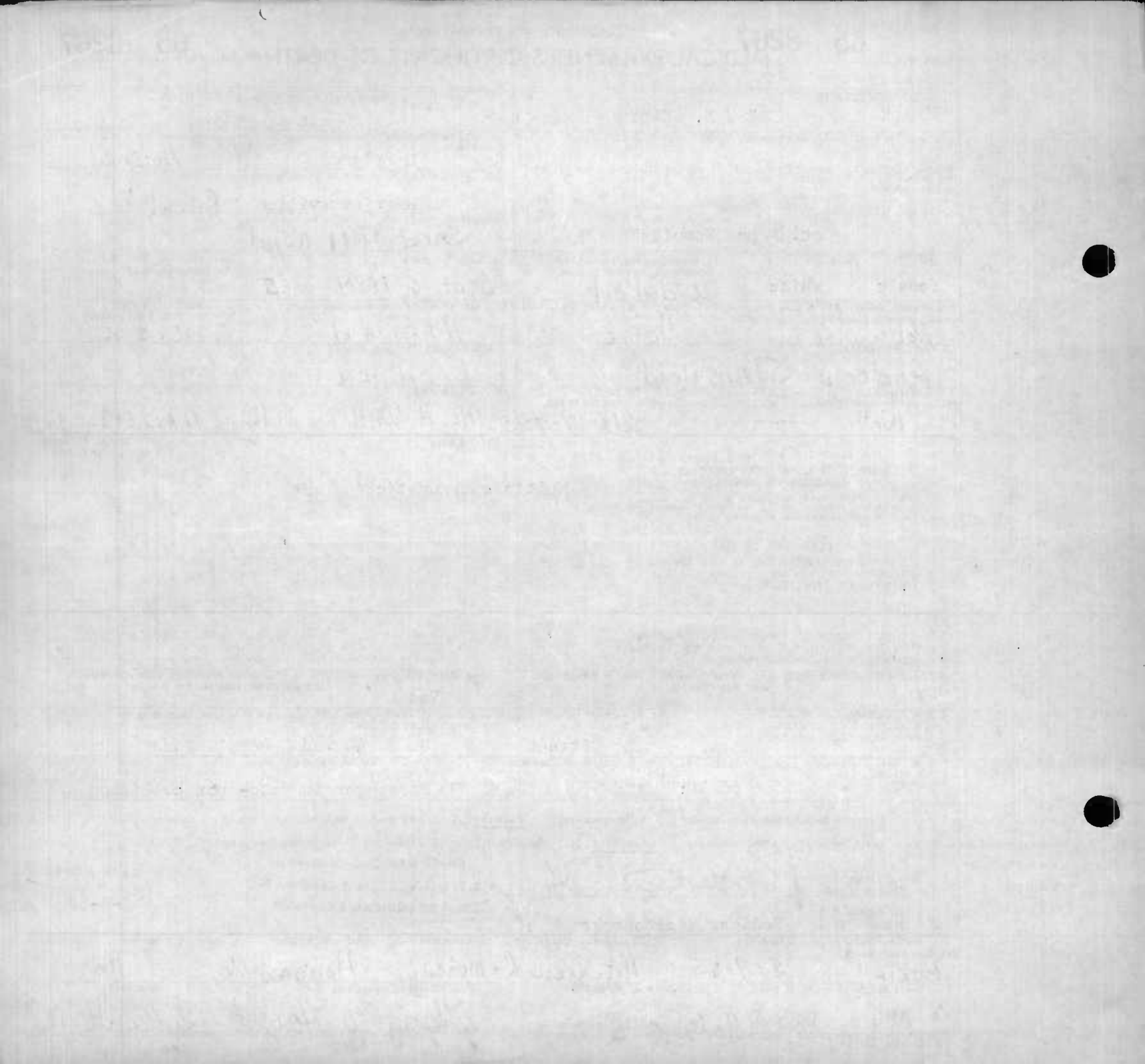
24C. FUNERAL DIRECTOR

ADDRESS

AUG 9 1965

Rudiger E. Breiteneker

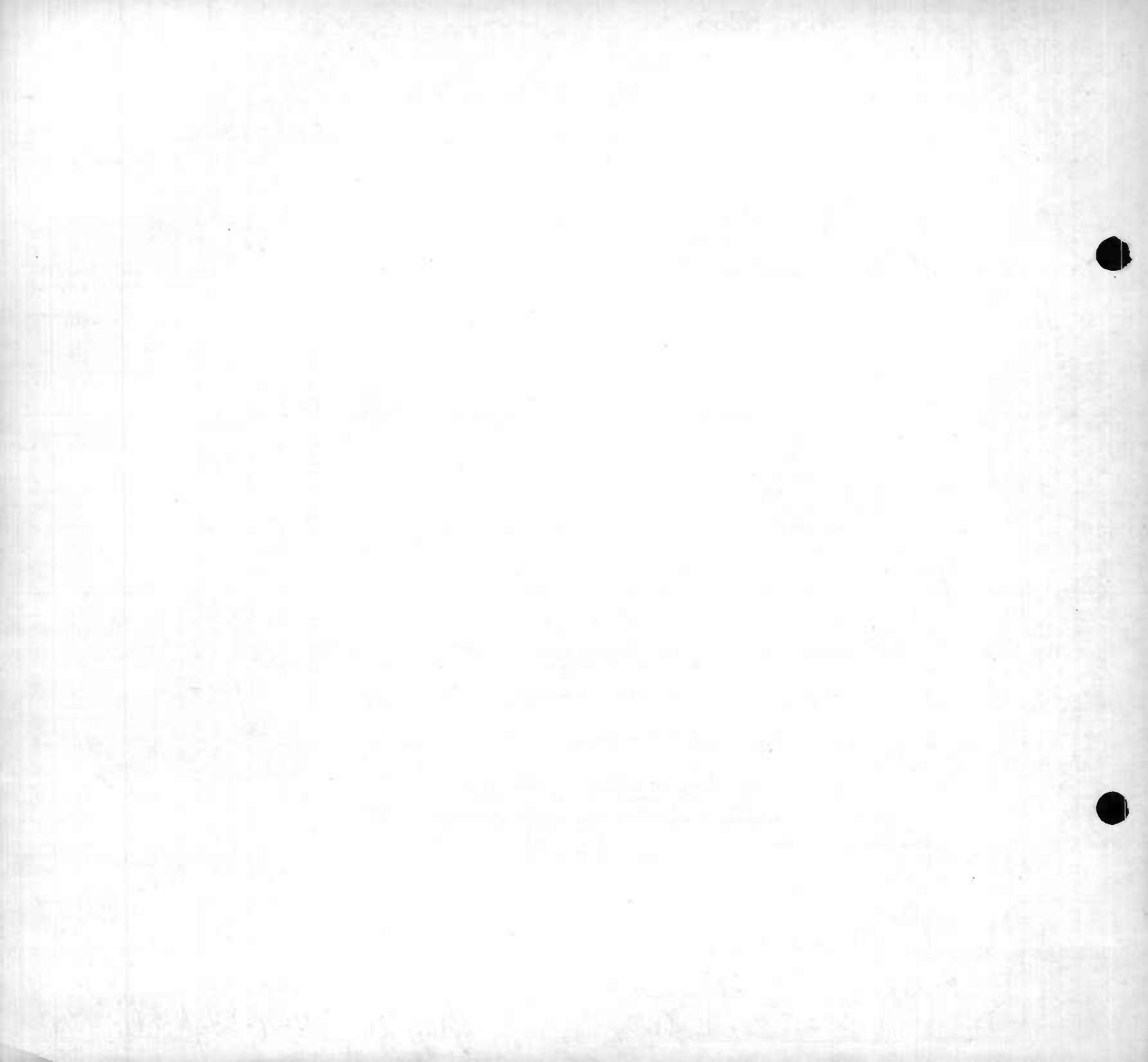
Harry W. Haight Lykesville, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

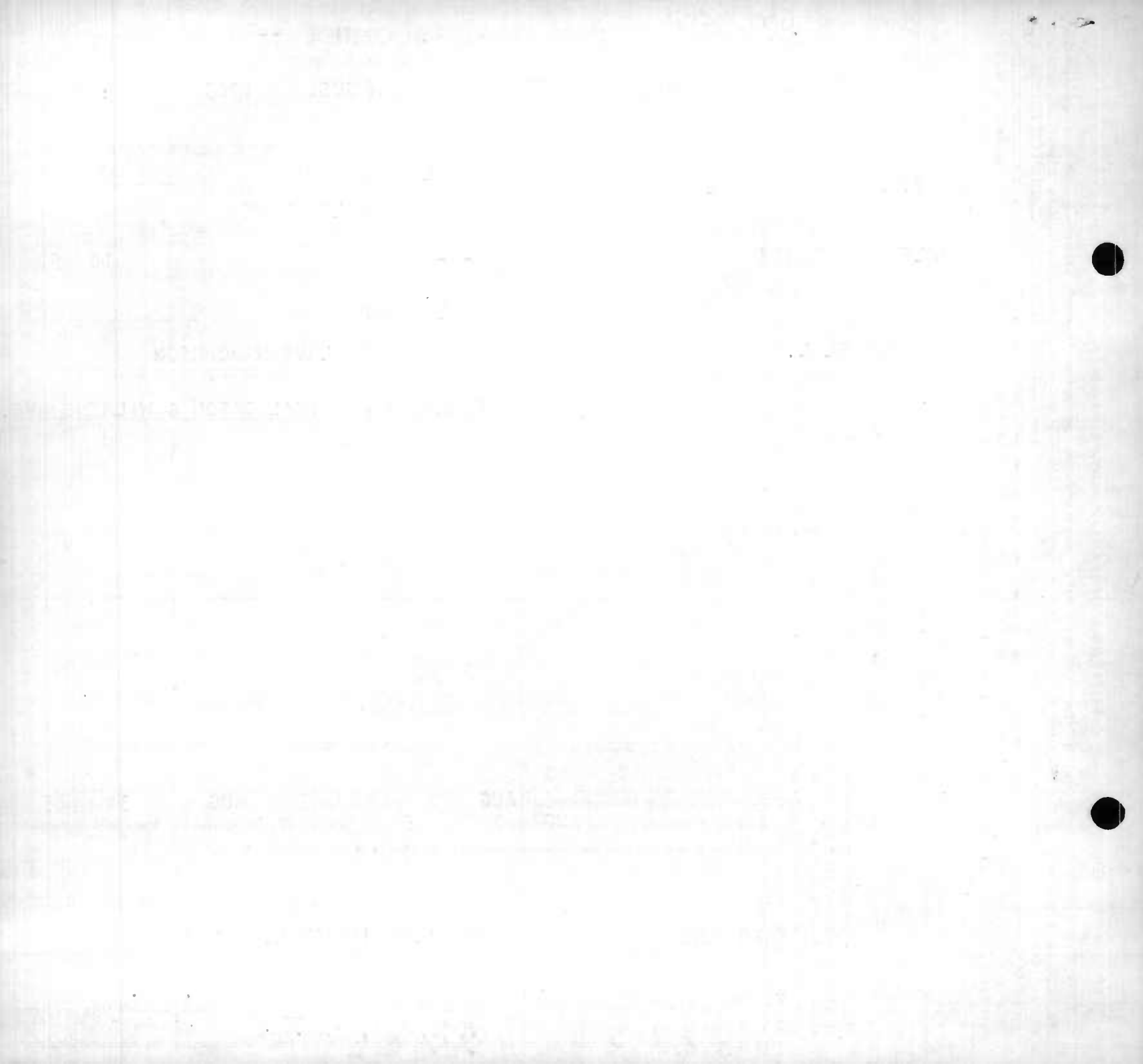
BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 65 8268	
BIRTH NO. 65 8268		CERTIFICATE OF DEATH								Registered No. 65 8268	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Max Bates						2. DATE AND HOUR OF DEATH 8.8.65 1:30 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore					
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hosp.						C. CITY OR TOWN (If outside city limits, write RURAL and give township) Joppa 33-00					
D. STREET ADDRESS (If rural, give location) 507 Trimble Rd.											
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH 9.14.18	9. AGE (In years last birthday) 46	11. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic				10B. KIND OF BUSINESS OR INDUSTRY Continental Can				11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joshua Bates						14. MOTHER'S MAIDEN NAME Emma Giffin					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW II				16. SOCIAL SECURITY NO.		17. INFORMANT wife			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I Acute Myocardial infarct						CAUSE OF DEATH (A) DUE TO ASCVD (B) DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH 4 hours		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 8.7.65 to 8.8.65 , that (I) (we) last saw the deceased alive on 8.8.65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE D. Suidenstrutts						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8.8.65			
23C. PHYSICIAN'S NAME (Type) D. Suidenstrutts						23D. ADDRESS M.D. Md. Gen. Hospital Balto. Md.					
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-11-65		24C. NAME OF CEMETERY or CREMATORY Fair View Cemetery		24D. LOCATION (City, town, or county) (State) Frederick Co. VA.					
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Gray W. Knight		ADDRESS Sylva, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

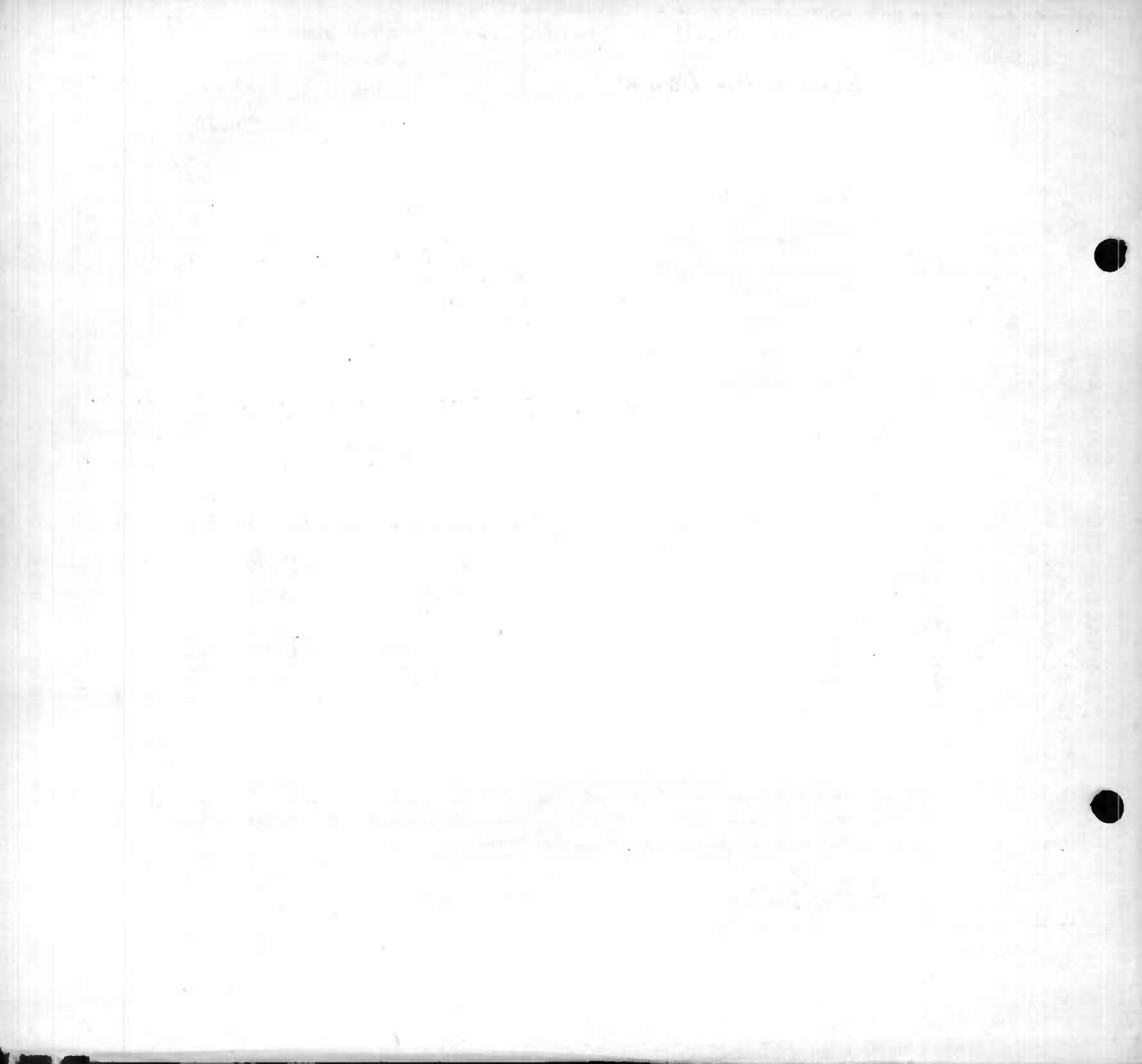
BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 65 8269	
BIRTH NO. 65 8269 M.E. CASE NO. 05-18978											
1. NAME OF DECEASED (Type or Print) BRANUM BABY BOY						2. DATE AND HOUR OF DEATH AUGUST 3 1965 7:45A M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL						4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27 D. STREET ADDRESS (If rural, give location) 1138 CIRCLE DRIVE					
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED		8. DATE OF BIRTH 8-2-65		9. AGE (In years last birthday)		10. Under 1 Yr. Months: Days: Hours: Min. 10 52	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME SAMUEL L.						14. MOTHER'S MAIDEN NAME BETTY LAVERN JOHNSON					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 776X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.						CAUSE OF DEATH (A) DUE TO Prematurity (B) DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH 11 hours		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from AUG 2 1965 to AUG 3 1965, that (I) (we) last saw the deceased alive on AUG 3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Humberto J. Hernandez						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED Aug. 3, 1965		
23C. PHYSICIAN'S NAME (Type) HUMBERTO HERNANDEZ						23D. ADDRESS M.D. ST AGNES HOSPITAL, 21229					
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 8-4 65		24C. NAME of CEMETERY or CREMATORY Good Shepherd				24D. LOCATION (City, town, or county) (State) Ellicott City. Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965				25B. NAME OF REGISTRAR R. E. Taylor				25C. FUNERAL DIRECTOR ADDRESS F. L. Higginbotham Ellicott City			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8270				BALTIMORE CITY HEALTH DEPARTMENT				REGISTERED NO. 65 8270			
M.E. CASE NO.				CERTIFICATE OF DEATH				Registered No. 65 8270			
1. NAME OF DECEASED (Type or Print) EVANS, LA Dawn				2. DATE AND HOUR OF DEATH AUGUST 6, 1965 11:40 P.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE MARYLAND B. COUNTY ALLEGANY							
33 THE JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) CUMBERLAND							
				D. STREET ADDRESS (If rural, give location) 51-02 BOX 646 A VALLEY ROAD							
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 6/17/65	9. AGE (in years, lost birthday) 2 months	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Cumberland, Md.			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME EVAN NORMAN EVANS				14. MOTHER'S MAIDEN NAME ESTHER M. Evans							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS Mr. Evan N. Evans, Cumberland, Md.					
18. 7-5-9-31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES				(A) LUNG DISEASE DUE TO				LIFE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) ? Suspected CONGENITAL HEART LESION DUE TO				LIFE			
				(C) OR PREMATUREITY & RESPIRATORY DISTRESS (LIFE)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				PYLORIC STENOSIS							
				PNEUMOTHORAX BILATERAL							
19A. DATE OF OPERATION 8/8/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PYLORIC STENOSIS		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from AUGUST 5, 1965 to AUGUST 6, 1965 , that (I) (we) last saw the deceased alive on AUGUST 6, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE S. D. Ravenel, M.D.				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 8/6/65			
23C. PHYSICIAN'S NAME (Type) S. D. RAVENEL (HOUSE STAFF)				23D. ADDRESS JOHNS HOPKINS HOSPITAL							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-9-1965		24C. NAME OF CEMETERY or CREMATORY Sunset Memorial Park		24D. LOCATION (City, town, or county) Cumberland, Md.		(State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. F...		25C. FUNERAL DIRECTOR James F. Scarpelli - Cumberland, Md.		ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8271				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8271	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Louis W. Buell</i>				2. DATE AND HOUR OF DEATH <i>8-7-65 11:10 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>SO. BALTA GEN. HOSP.</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>13-07</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTO.</i> D. STREET ADDRESS (If rural, give location) <i>3645 ELM. AVE.</i>			
5. SEX <i>MALE</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>3/25/05</i>	9. AGE (In years last birthday) <i>60</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>SLABWRIGHT CO.</i>		11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>?</i>				14. MOTHER'S MAIDEN NAME <i>?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>214-65-5155</i>		17. INFORMANT <i>GLADYS BUELL 3645 ELM AVE.</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Acute Peritonitis</i> DUE TO <i>Ruptured Viscose Complicated</i> DUE TO <i>by Metastatic Carcinoma</i>				INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>7-26-1965</i> to <i>8-7-1965</i> , that (I) (we) last saw the deceased alive on <i>8-7-1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Kenneth P. Bonovich</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8-8-65</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>8/10/65</i>		24C. NAME of CEMETERY or CREMATORY <i>CEDAR HILL</i>		24D. LOCATION (City, town, or county) (State) <i>A.A. CO.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 9 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber M.D.</i>		25C. FUNERAL DIRECTOR <i>Paul E. Charnett</i>		ADDRESS <i>3617 Chestnut Ave.</i>	

11.22.1942

2000

2000

MAILED

WHITE

RECEIVED

1942

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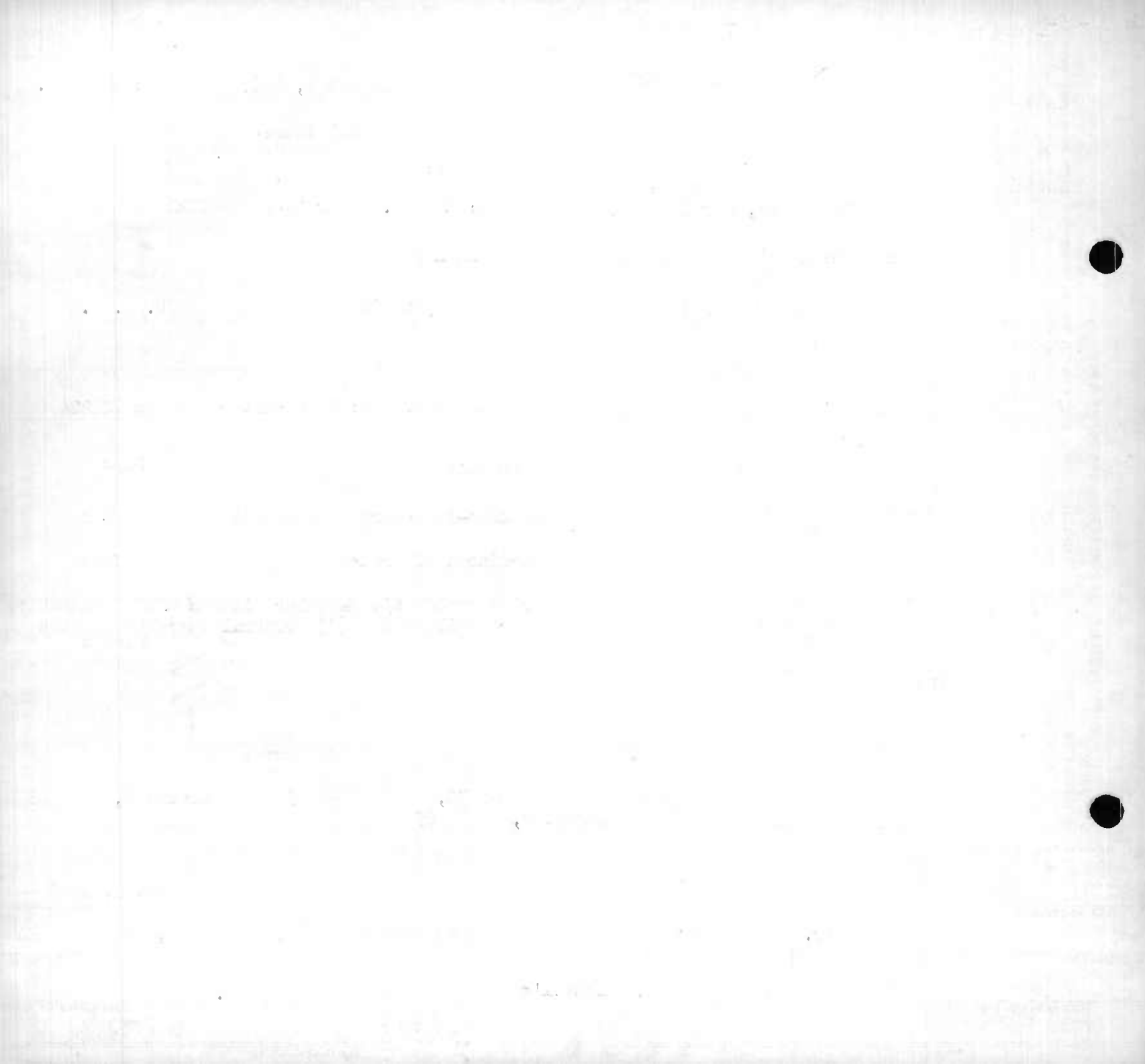
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. R-552		65 8272		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8272	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Carrie Romanoskie				2. DATE AND HOUR OF DEATH August 9, 1965 6:15 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224				A. STATE Maryland B. COUNTY Baltimore			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				D. STREET ADDRESS (If rural, give location) 7817 St. Clair Lane #21222			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 2-12-85	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS		10B. KIND OF BUSINESS OR INDUSTRY DRESS FACTORY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Rhodes				14. MOTHER'S MAIDEN NAME NOT KNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 179-16-6232		17. INFORMANT ADDRESS RECORDS: BCH: 4940 Eastern Avenue #21224			
18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia DUE TO Broncho-Pulmonary Metastasis DUE TO Carcinoma of Breast DUE TO Arteriosclerotic Vascular Disease with Congestive Heart Failure and (R) Cerebral Vascular Disease DUE TO Months				INTERVAL BETWEEN ONSET AND DEATH Days Months 3 Years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 30, 19 65 to August 9, 19 65 , that (I) (we) lost saw the deceased alive on August 9, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. David Curtiss				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 9, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. David Curtiss				23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland #24			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/12/1965		24C. NAME of CEMETERY or CREMATORY St. Michael's Cemetery		24D. LOCATION (City, town, or county) (State) Shamokin, Pa.	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Wm. J. Dickner & Sons		ADDRESS 114 PA. AVE.	



BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 8273 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 8273

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM BOYKIN

2. DATE AND HOUR PRONOUNCED DEAD

August 5, 1965 5:20 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31 City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Edgemere

D. STREET ADDRESS (If rural, give location)

18 Willow Avenue

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

July 24, 1935

9. AGE (In years
last birthday)

30.5

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

School

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Charles N. Boykin

14. MOTHER'S MAIDEN NAME

Mary Gossman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

Korea

16. SOCIAL
SECURITY NO.

217-30-5119

17. INFORMANT

Marion Boykin 18 Willow Ave.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Cranio-cerebral injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Factory

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2116 Sparrows Point Road

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour) (Minute)

8 2 65 8:00m

21E. INJURY OCCURRED

WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

Fell during altercation

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-6-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/9/65

23C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Co. Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 9

1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Ullrich Funeral Home Dundalk, Md.

ADDRESS

STANDARD CO. 1000 THE UNIVERSITY OF CALIFORNIA LIBRARY

1000

1000

1000

WALLS & DOOR



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>M-342</u> 65 8274				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65</u> 8274	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <u>William Matlack</u>			
2. DATE AND HOUR OF DEATH <u>8-7-65</u> <u>6:05 P</u> M.				3. PLACE OF DEATH (If not in hospital or institution, give street address or location) CERTIFICATE AMENDED Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>19-03</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
D. STREET ADDRESS (If rural, give location) <u>1318 McHenry Street - #21223</u>				5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>			
8. DATE OF BIRTH <u>6-8-05</u> 9. AGE (In years lost birthday) <u>60</u>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>			
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Jacob L. Matlack</u>				14. MOTHER'S MAIDEN NAME <u>Lula May Golden</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-12-2138</u>			
17. INFORMANT <u>RECORDS-BCH-4940 Eastern Avenue-21224</u>				ADDRESS			
18. <u>193.0 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) <u>Cardio Respiratory Failure</u> Minutes DUE TO (B) <u>Metastatic Carcinoma to Brain-3 months</u> DUE TO (C) _____			
19A. DATE OF OPERATION <u>6-12-65</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Posterior Fossa Exploration NO</u>			
20A. AUTOPSY? (Yes or No) _____				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR? _____			
22. I certify that (I) (this hospital) attended the deceased from <u>6-9</u> 19 <u>65</u> to <u>8-7</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>8-7</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE <u>Dr. Donald Baltzan</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			
23B. DATE SIGNED <u>8-7-65</u>				23C. PHYSICIAN'S NAME (Type) <u>Dr. Donald Baltzan</u> M.D. 23D. ADDRESS <u>#21224 4940 Eastern Avenue-Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>				24B. DATE <u>Aug 8/65</u>			
24C. NAME OF CEMETERY or CREMATORY <u>Barrenwood Cem</u>				24D. LOCATION (City, town, or county) (State) <u>Barrenwood W. Va</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 9 1965</u>				25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>			
25C. FUNERAL DIRECTOR <u>Philip H. Lewis</u>				25D. ADDRESS <u>2024 Orleans St #31</u>			

vs 123 Signed by funeral director. 8/17/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 8275		CERTIFICATE OF DEATH				Registered No. 65 8275			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SARAH NITZBERG				2. DATE AND HOUR OF DEATH AUGUST 8, 1965 11:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 27-13			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 70 House in Pines - Belvedere Ave						C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
D. STREET ADDRESS (If rural, give location) BELVEDERE AVE									
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW		8. DATE OF BIRTH 4-6-1895	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ISIDORE						14. MOTHER'S MAIDEN NAME SHANDEL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS SAM GOLDBERG - 1190 W BELVEDERE AVE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) E 900.10 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						CAUSE OF DEATH BRAIN INJURY (FALL) PULMONARY EMBOLISM ACUTE PULMONARY EMBOLISM		INTERVAL BETWEEN ONSET AND DEATH Sept 11, 1964 Sept 11, 1964 AUG 8, 1965	
MEDICAL CERTIFICATION									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) BALTO CITY OSWEGO AVE (ADDRESS??)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) Sept 11 1964 3 AM			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>			21F. HOW DID INJURY OCCUR? FELL down cellar steps returning from bath room			
22. I certify that (I) (this hospital) attended the deceased from September 11, 1964 to August 8, 1965, that (I) (we) last saw the deceased alive on August 8, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE MILTON E. LOWMAN M.D.						23B. DATE SIGNED 8-8-65			
23C. PHYSICIAN'S NAME (Type) MILTON E. LOWMAN M.D.						23D. ADDRESS 4843 PARK HEIGHTS AVE BALTO, MD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE AUG. 9, 1965		24C. NAME OF CEMETERY or CREMATORY MT CARMEL		24D. LOCATION (City, town or county) (State) BALTO MD			
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965			25B. NAME OF REGISTRAR J. E. FALKENBERG			25C. FUNERAL DIRECTOR ADDRESS SYLVANUS LEWIS & SON, INC. 3319 OLYMPIA AVE			

REPORT OF THE
COMMISSIONER OF THE
LAND OFFICE

TO THE
LEGISLATIVE ASSEMBLY

IN
ANSWER
TO A
RESOLUTION
PASSED
BY THE
LEGISLATIVE
ASSEMBLY
ON THE
11TH
MAY 1902

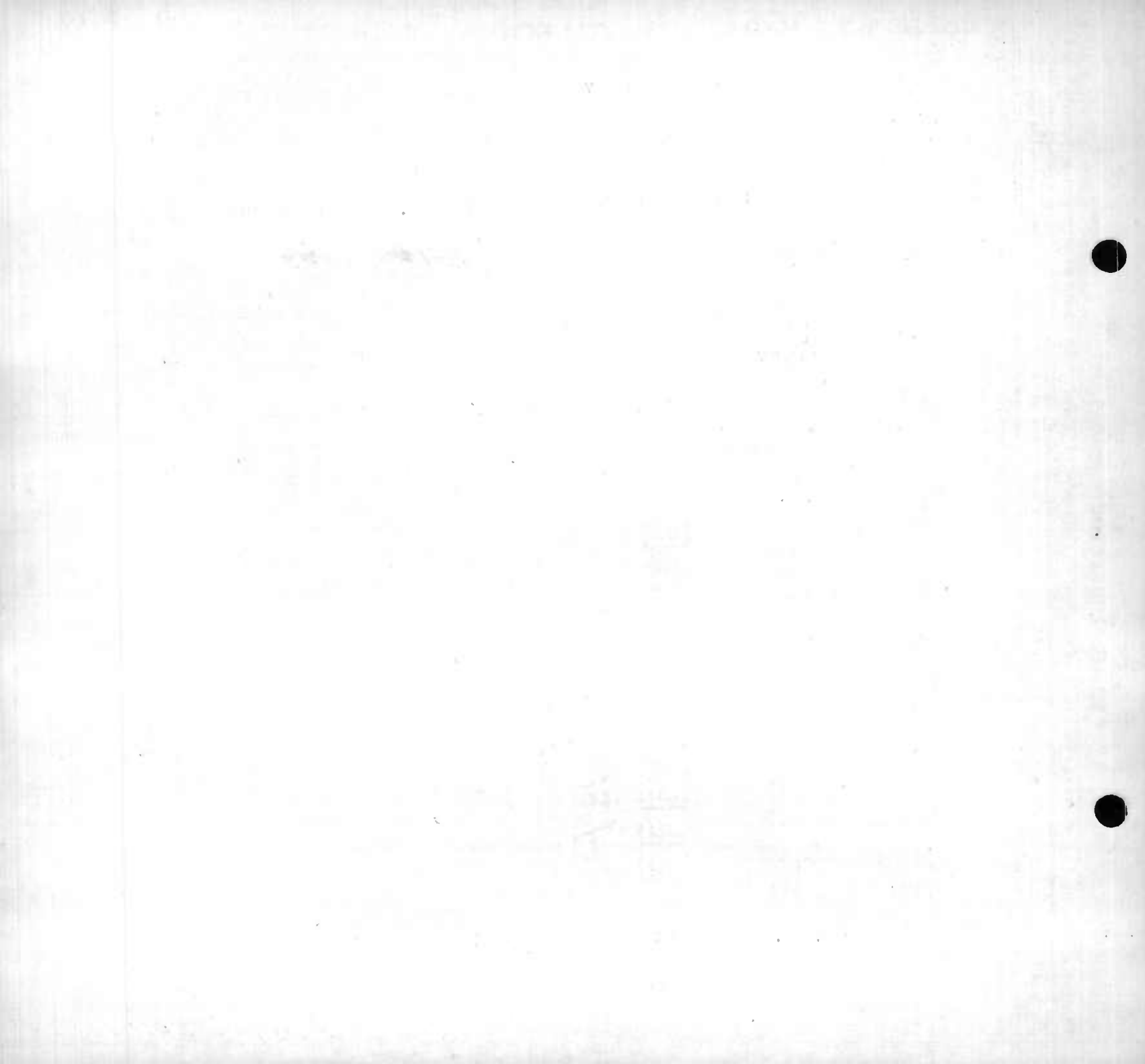
PRINTED
BY THE
GOVERNMENT
PRINTERS
ST. JOHN'S

MILTON E. LOWMAN M.D. & J. PARK HEICHTS
MILTON E. LOWMAN M.D. & J. PARK HEICHTS
MILTON E. LOWMAN M.D. & J. PARK HEICHTS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8276		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8276	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
SHANON (SHANNON) BAILEY		8-8-65		1 500 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSPITAL		MARYLAND		14-01	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE			
		D. STREET ADDRESS (If rural, give location)			
		711 W. NORTH AVENUE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
MALE	NEGRO	SEPARATED	2-12-1902	63	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
LABORER		Railroad		Lancaster C. S. C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
CHARLES BAILEY		JANE		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		705-03-9603		B. J. FORD JAWKINS 2023 Ruxton Ave	
18. 392X1		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Renal failure & uremia		10 days.	
(This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)		DUE TO			
ANTECEDENT CAUSES		(B) Chronic renal disease		Unknown	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO			
		(C) Hypotension 2° to hemorrhage		10 days.	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
37-28-65		Benign prostatic hypertrophy		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 7-16 1965 to 8-8 1965, that (I) (we) lost saw the deceased alive on 8-8 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
J. M. LEBOWITZ				8-8-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		601 N. Broadway			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/11/65		Mt Auburn	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 9 1965		Robert E. Fink		J. J. Fink 6381 G. L. Moore	
				ADDRESS	

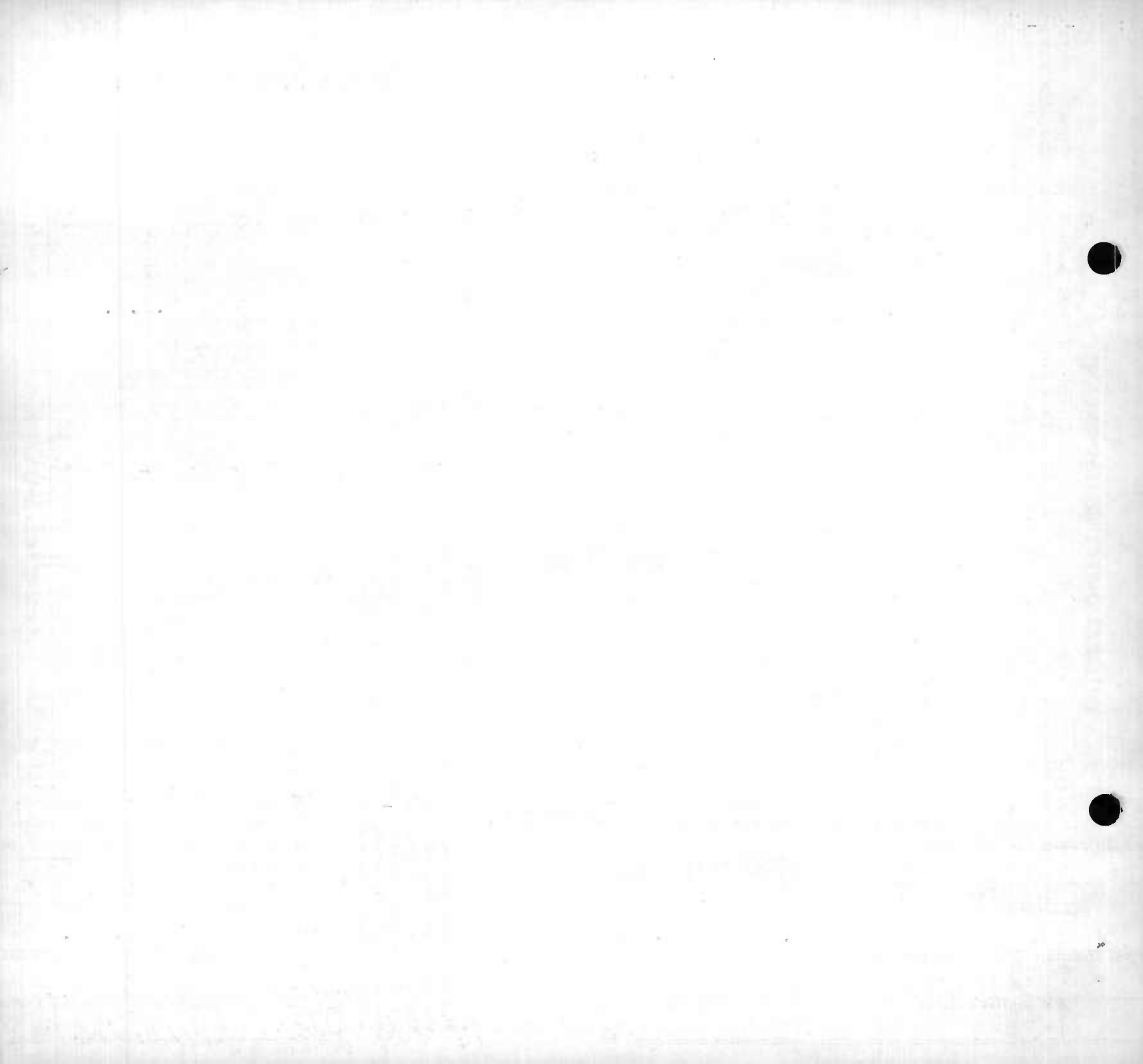


S: 43-71-641

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

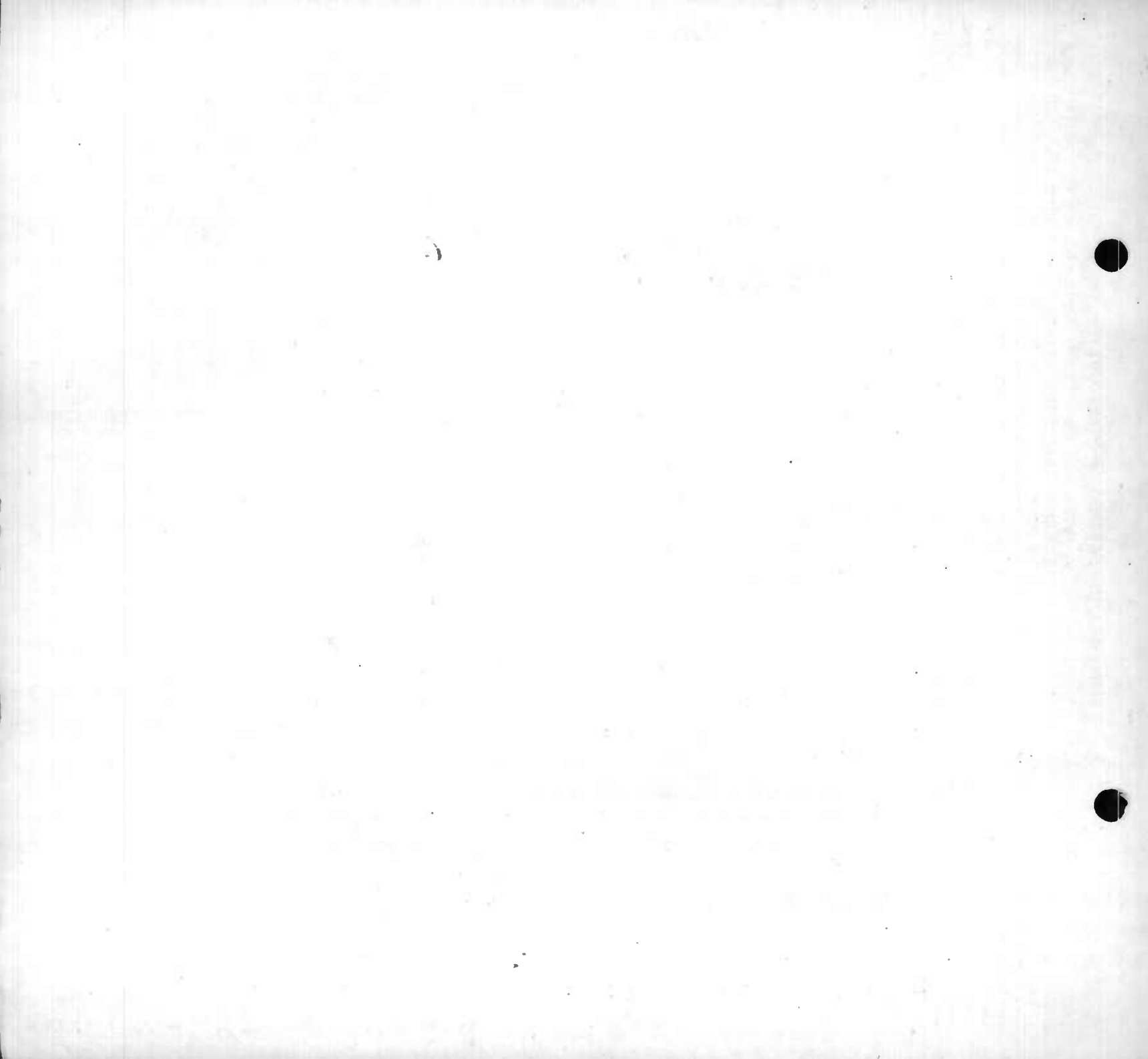
H 200 BIRTH NO. 65 8277		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8277	
M.E. CASE NO. 65 8277		1. NAME OF DECEASED (Type or Print) Virginia Hicks		2. DATE AND HOUR OF DEATH August 6, 1965 8:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		8-06	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 1630 North Broadway 21213	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 9-27-20	9. AGE (In years last birthday) 44	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Private		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charlie Barnes		14. MOTHER'S MAIDEN NAME Adley Walker	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-24-6462		17. INFORMANT ADDRESS RECORDS: BCH: 4940 Eastern Avenue #24	
18. 200.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Reticulum Cell Disorder DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2-3-Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 6, 1965 to August 6, 1965, that (I) (we) last saw the deceased alive on August 6, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. Rathbun		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 6, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. Howard K. Rathbun		23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. #24			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-10-65		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR R. E. Fisher		25C. FUNERAL DIRECTOR R. E. Fisher	
25D. ADDRESS 1412 E. Preston St.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

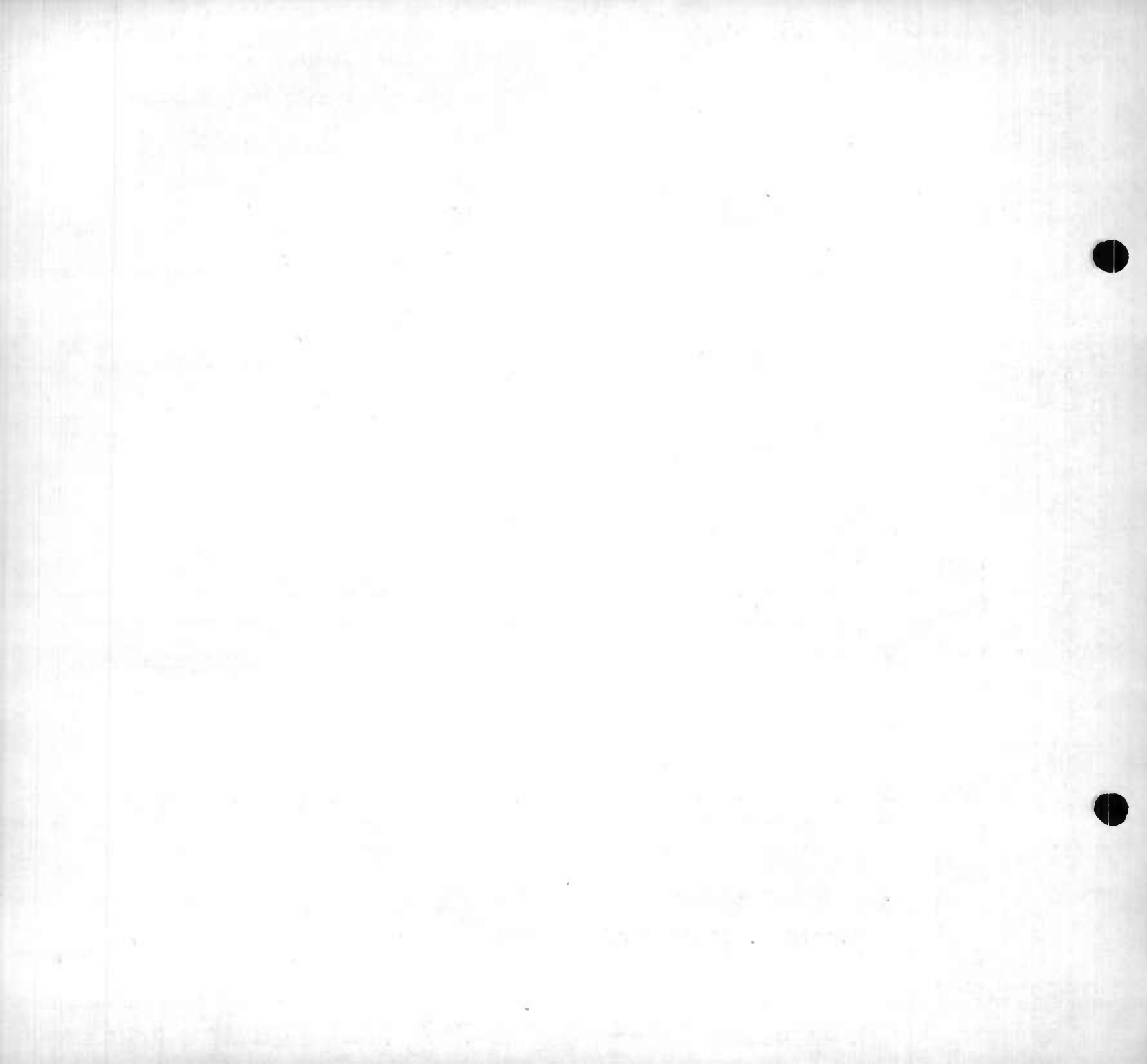
BIRTH NO. 65 8278				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8278	
1. NAME OF DECEASED (Type or Print) MARY FLORENCE OREFACE				2. DATE AND HOUR OF DEATH 8/6/65 7 30 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE HOSPITAL FOR THE WOMEN OF MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1259 EAST NORTH AVE			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH April 6, 1907	9. AGE (in years last birthday) 58	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) BOSTON, MASS.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME CAMPBELL				14. MOTHER'S MAIDEN NAME —			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. 220-30-6909		17. INFORMANT CHART		ADDRESS —	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 2,60X I Pulmonary edema ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) Diabetic acidosis. (B) Antecedent heart disease Renal shut down II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Antecedent acidosis				INTERVAL BETWEEN ONSET AND DEATH 7-30 pm 8/5 → 7-30 AM 8/6/65			
19A. DATE OF OPERATION 8/5/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) awaited. NONE		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) —		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> / Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —			
22. I certify that (I) (this hospital) attended the deceased from 8/5/65 1965 to 8/6 1965, that (I) (we) last saw the deceased alive on 8/7-30 AM 8/6/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE IRANI F.A. (resident)				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/6/65	
23C. PHYSICIAN'S NAME (Type) IRANI F.A. (resident)				23D. ADDRESS —			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/9/65		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Joseph H. Zannanish		ADDRESS 263 S. Conley St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

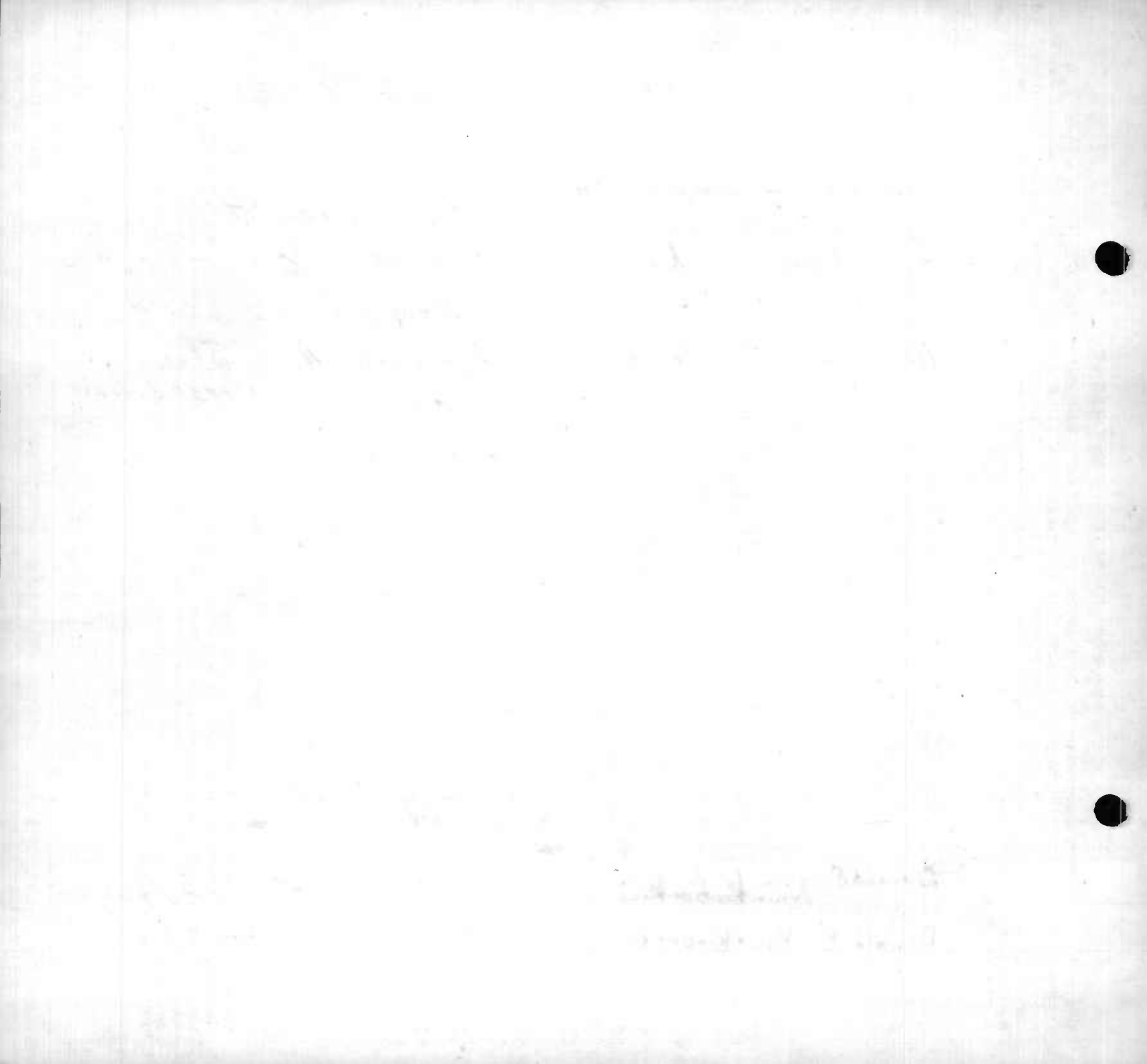
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8279	
BIRTH NO. 65 8279		CERTIFICATE OF DEATH	
M.E. CASE NO.		DATE AND HOUR OF DEATH July 31 / 1965 9³⁰ A.M.	
1. NAME OF DECEASED (Type or Print) Rowe George Frank Jr		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital		A. STATE Maryland B. COUNTY 19-03	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Maryland #23	
		D. STREET ADDRESS (If rural, give location) 1095 Stricker St	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4/12/85
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Mich	9. AGE (In years last birthday) 80
13. FATHER'S NAME Wallace Rowe		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME Mary Hulsey	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Wife 1095 Stricker St	
18. 420.11		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Pulmonary Embolism Massive 1 week	
		(B) Coronary Thrombosis 1 week	
		(C) 	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 23 1965 to July 31 1965 , that (I) (we) lost saw the deceased alive on July 31 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Harold C. Standiford		23B. DATE SIGNED July 31, 1965	
23C. PHYSICIAN'S NAME (Type) Harold C. Standiford		23D. ADDRESS University Medical School	
24A. BURIAL CREMATION, REMOVAL (Specify) AUG 6 1965		24B. DATE AUG 6 1965	
24C. NAME OF CEMETERY UNIVERSITY MEDICAL SCHOOL		24D. LOCATION MORTUARY SERVICE - BCHD	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

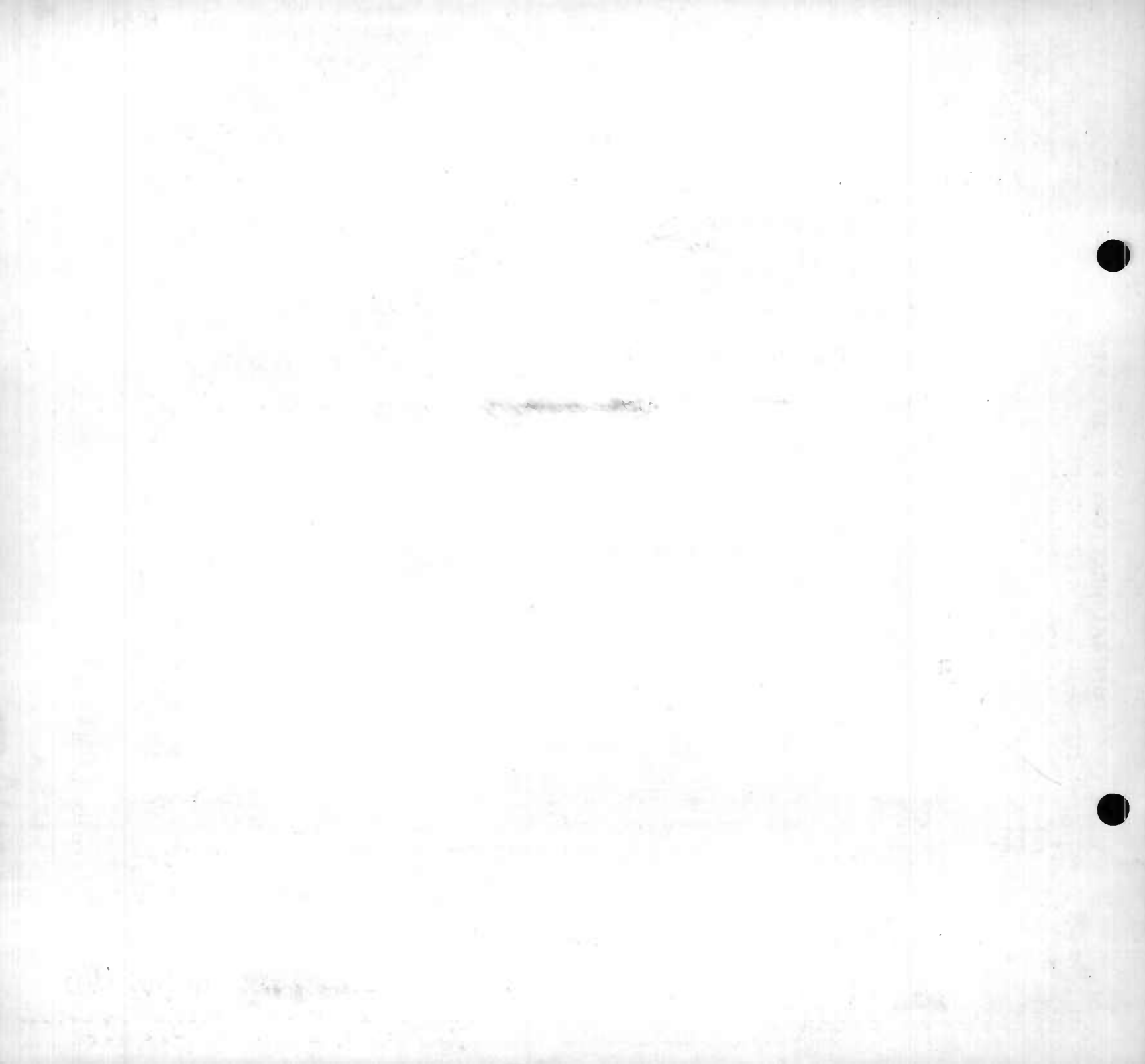
BIRTH NO. 65 8280				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8280	
1. NAME OF DECEASED (Type or Print) <i>Baby Girl Crosby</i>				2. DATE AND HOUR OF DEATH <i>27 July 65 1:52 PM</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland Hosp</i>				A. STATE <i>MD</i> B. COUNTY <i>6-04</i>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
D. STREET ADDRESS (If rural, give location) <i>1927 Orleans St.</i>							
5. SEX <i>♀</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MM</i>	8. DATE OF BIRTH <i>26 July 65</i>	9. AGE (In years lost birthday) <i>0</i>	If Under 1 Yr. Months Days Hours Min. <i>- - 19 30</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William F. Crosby</i>				14. MOTHER'S MAIDEN NAME <i>Barbara A. Strong</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>0</i>		17. INFORMANT <i>Mother</i> ADDRESS <i>1927 Orleans</i>	
18. <i>776X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Prematurity</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>19 hrs 30 min</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>26 July 1965</i> to <i>27 July 1965</i> , that (I) was lost saw the deceased alive on <i>26 July 1965</i> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.							
23A. SIGNATURE <i>Donald E. Knickerbocker</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>27 July 65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Donald E. Knickerbocker</i>				23D. ADDRESS <i>University of Maryland Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>AUG 6 1965</i>		24B. DATE <i>AUG 9 1965</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Robert E. Farley</i>		24D. LOCATION (City, town or county) (State) <i>Baltimore MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 9 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <i>MORTUARY SERVICE - BCHD</i>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8281		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8281	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARY L SCHERER		2. DATE AND HOUR OF DEATH August 3, 1965 7:15 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Lutheran Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Anne Arundel		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE Glen Burnie 52-00	
5. SEX Female		6. RACE White		7. MARRIED NEVER MARRIED MARRIED	
8. DATE OF BIRTH 1-18-02		9. AGE (In years last birthday) 63		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Victor Martel		14. MOTHER'S MAIDEN NAME Murowski	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-48-9917		17. INFORMANT Mary Dolores Scherer	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 602X11-260X		CAUSE OF DEATH Septicemia		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO		R. pyelonephritis		nephro-lithiasis + Diabetes mellitus	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 7-29-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED STONE, RT KIDNEY		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 17, 1965 to August 3, 1965 , that (I) (we) last saw the deceased alive on August 3, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Adolfo G. de Perio		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 3, 1965	
23C. PHYSICIAN'S NAME (Type) DR. L. SCHERER & ABRAMSON		M.D. Lutheran Hosp. of Md.		23D. ADDRESS	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/65		24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery	
24D. LOCATION Anne Arundel MARYLAND		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Charles L. Stevens	
25C. FUNERAL DIRECTOR Charles L. Stevens		ADDRESS 77150A E. Fort Avenue			



CERTIFICATE OF DEATH

Registered No. 65 8282

BIRTH NO.

65 8282

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Alexander Jacobs

2. DATE AND HOUR OF DEATH

8/5/65

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1225 Haubert St.

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

5/15/92

9. AGE (In years
lost birthday)

73

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Driller

10B. KIND OF BUSINESS OR INDUSTRY

Md. Drydock

11. BIRTHPLACE (State or foreign country)

Lithuania

12. CITIZEN OF
WHAT COUNTRY?

Lithuania

13. FATHER'S NAME

Seman Jacobs

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-05-5632

17. INFORMANT

Mrs. Julia Kelly 3225 Tartarkey Court

ADDRESS

18. 420.1 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenio, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION lost.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/15/59 to 8/4/65,
that (I) (we) last saw the deceased alive on 5/26/65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Sidney R. Gehlert

M.D.

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

8/6/65

23C. PHYSICIAN'S
NAME (Type)

Sidney R. Gehlert

23D. ADDRESS

M.D. 4700 Pennington Ave. Balto. #26, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/9/65

24C. NAME OF CEMETERY OR CREMATORY

Glen Haven Cemetery

24D. LOCATION

(City, town, or county)

(State)

Anne Arundel, Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 9 1965

25B. NAME OF REGISTRAR

Robert E. Fairbank

25C. FUNERAL DIRECTOR

Charles L. Stevens Funeral Home, Inc.

ADDRESS

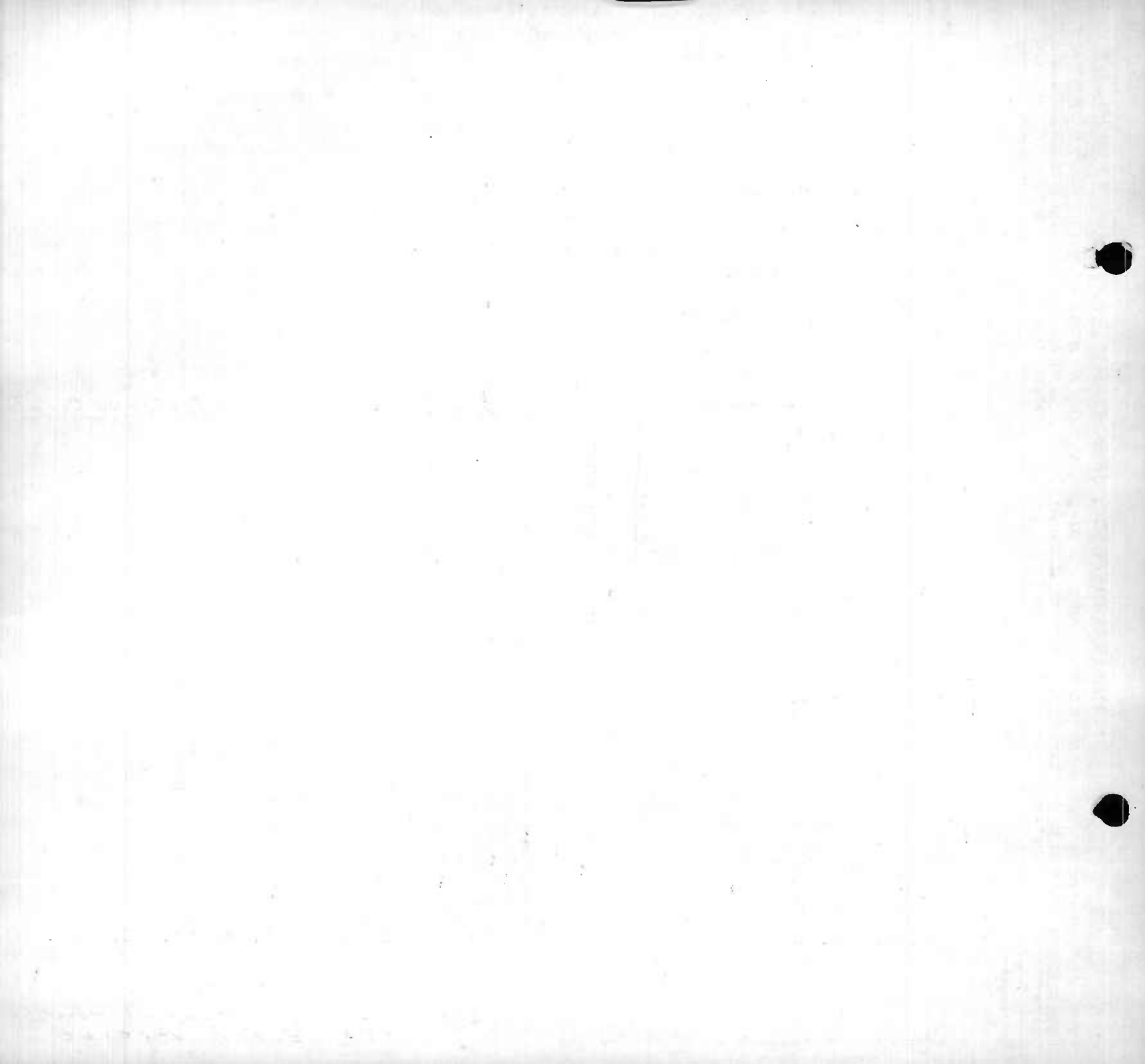
7715 E. FORT AVENUE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

For Approval
by Medical
Examiner

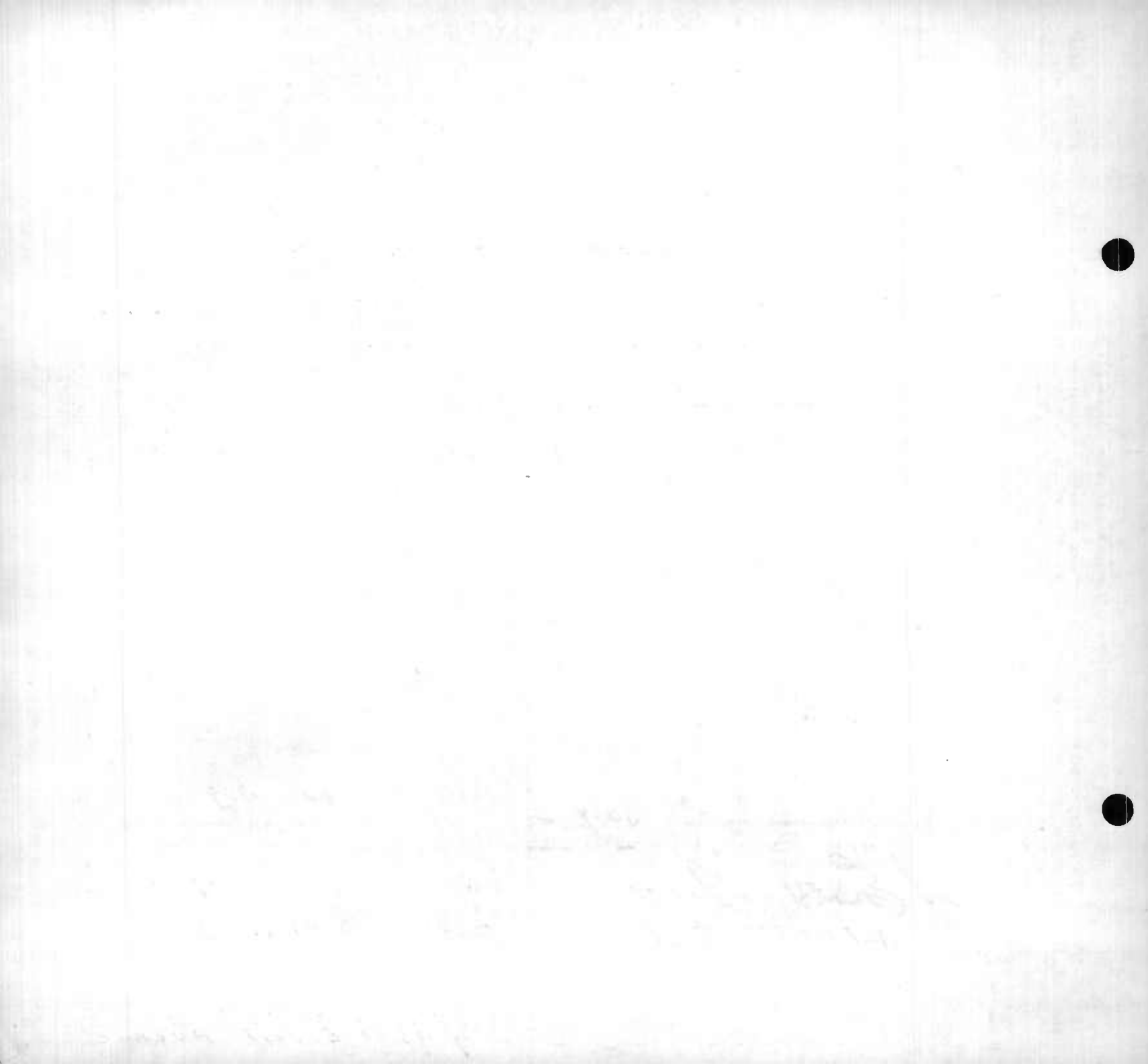
CERTIFICATION APPROVED BY
CHIEF OF ASST. MED. EXAMINER



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8283				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8283	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Victoria M. Haspert				2. DATE AND HOUR OF DEATH August 6, 1965 7 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <div style="text-align: center;">1510 Latrobe Park Terrace</div>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2401 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1510 Latrobe Park Terrace			
5. SEX <div style="text-align: center;">F</div>	6. RACE <div style="text-align: center;">W</div>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <div style="text-align: center;">Married</div>	8. DATE OF BIRTH <div style="text-align: center;">1/16/15</div>	9. AGE (In years lost birthday) <div style="text-align: center;">50</div>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clothing Worker		10B. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center;">-----</div>		11. BIRTHPLACE (State or foreign country) <div style="text-align: center;">Maryland</div>		12. CITIZEN OF WHAT COUNTRY? <div style="text-align: center;">U.S.A.</div>	
13. FATHER'S NAME <div style="text-align: center;">Joseph Golebiewski</div>			14. MOTHER'S MAIDEN NAME <div style="text-align: center;">Tillie Krzykowski</div>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <div style="text-align: center;">No</div>		16. SOCIAL SECURITY NO. <div style="text-align: center;">220-22-6294</div>		17. INFORMANT ADDRESS: Terrace 1510 Latrobe Park			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <div style="text-align: center;">201X I</div>				CAUSE OF DEATH (A) Hodgkins Disease DUE TO (B) 18 Mos. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <div style="text-align: center;">0</div>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <div style="text-align: center;">NO</div>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 1964 to Aug 6 1965, that (I) (we) last saw the deceased alive on July 20 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <div style="text-align: center;">J. Emmett Queen</div>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <div style="text-align: center;">8/7/65</div>	
23C. PHYSICIAN'S NAME (Type) <div style="text-align: center;">J. EMMETT QUEEN</div>				23D. ADDRESS <div style="text-align: center;">Medical Arts Bldg.</div>			
24A. BURIAL CREMATION, REMOVAL (Specify) <div style="text-align: center;">Burial</div>		24B. DATE <div style="text-align: center;">8/9/65</div>		24C. NAME OF CEMETERY or CREMATORY <div style="text-align: center;">Holy Cross Cemetery</div>		24D. LOCATION (City, town, or county) (State) <div style="text-align: center;">Anne Arundel, Maryland</div>	
25A. DATE REC'D BY HEALTH DEPT. <div style="text-align: center;">AUG 9 1965</div>		25B. NAME OF REGISTRAR <div style="text-align: center;">Robert E. Farber</div>		25C. FUNERAL DIRECTOR <div style="text-align: center;">Charles L. Stevens Funeral Home, Inc.</div>			
				ADDRESS <div style="text-align: center;">1501 E. Fort Avenue</div>			



BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		65 8284	
M.E. CASE NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
HENRY J. TRENTLER, SR.			8/9/65		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Maryland		
Union Memorial Hospital			B. COUNTY Balto.		
			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		
			D. STREET ADDRESS (If rural, give location)		
			7715 Hillsway Ave.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.
male	white	Married	7-30-1917	48	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
ACCOUNTING DEPT.		BETH. STEEL CO.		BALTO., MD.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
HERBERT TRENTLER			ADELAIDE EINHAUS		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown); (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		212-07-6943		MRS. CATHERINE TRENTLER SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
Arteriosclerotic cardiovascular disease					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(A) DUE TO		
			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				no	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER		DATE SIGNED	
Werner U. Spitz, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		8/10/65	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
BURIAL		8/13/65		MORELAND MEMORIAL PARK	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
AUG 9 1965		Robert E. Taylor, M.D.		LEONARD J. RUCK, INC., BALTO., MD. 21214	
23D. LOCATION (City, town, or county)		23E. LOCATION (State)			
BALTIMORE, MARYLAND					

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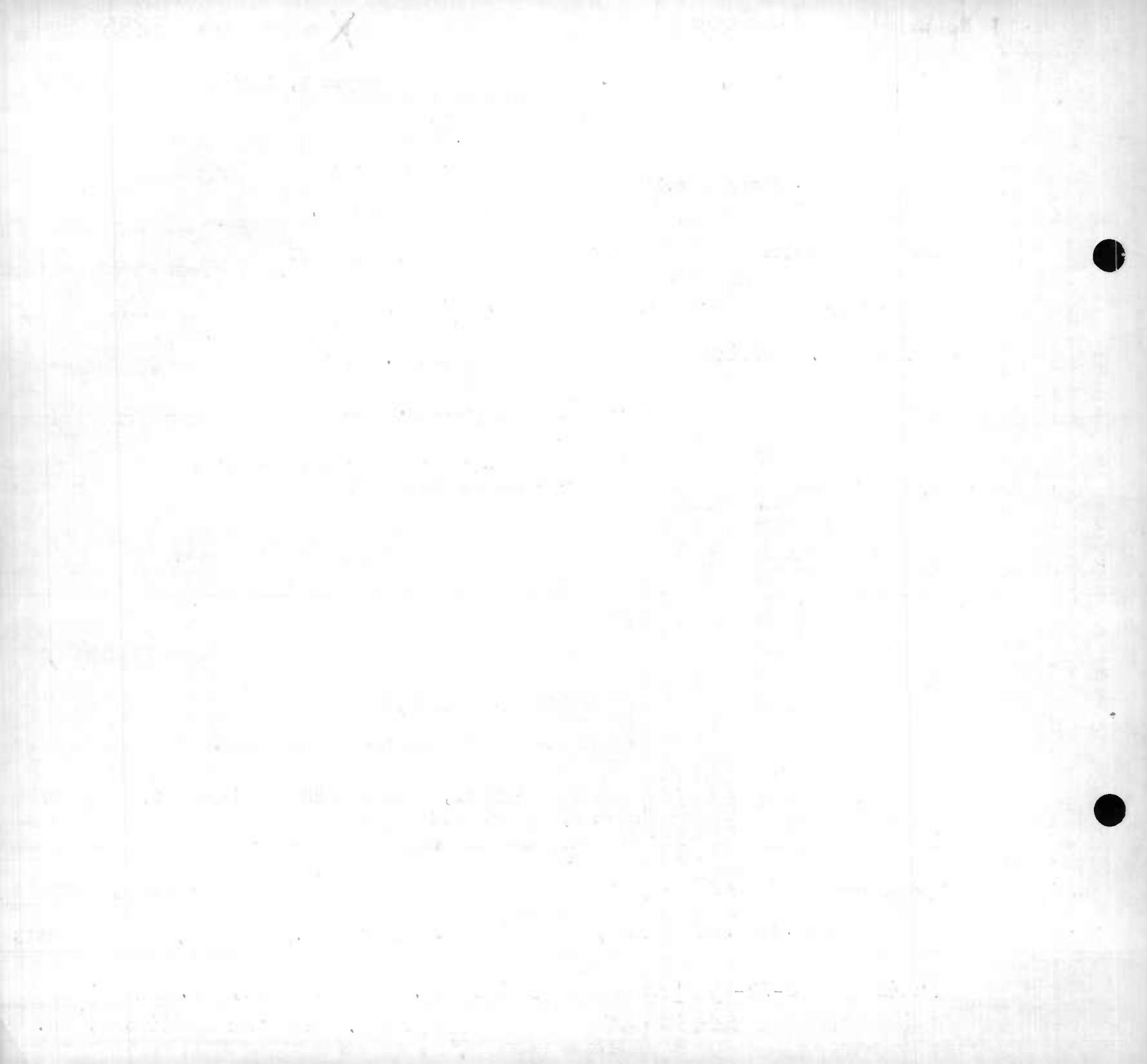
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

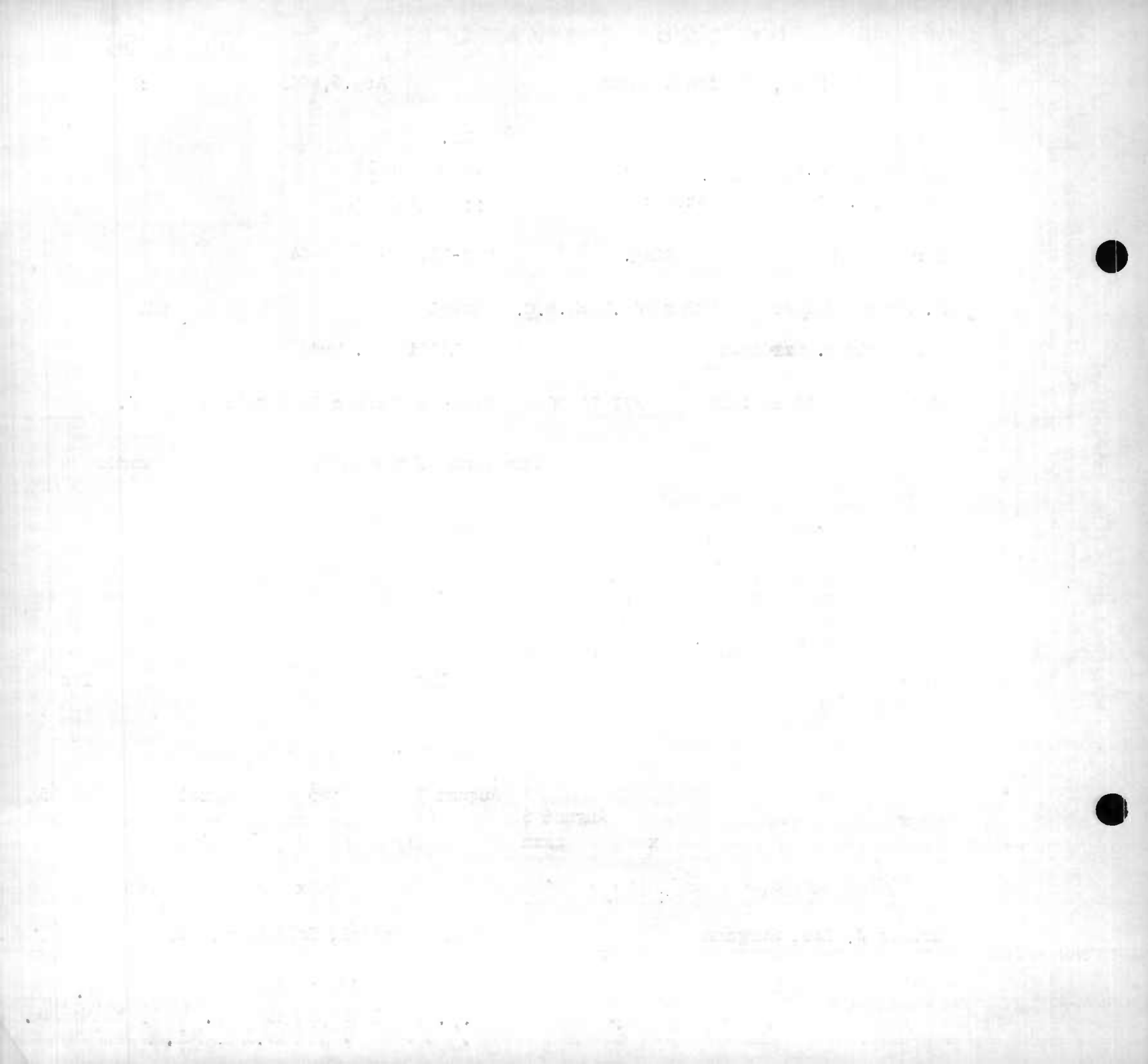
BIRTH NO. 65 8285		BALTIMORE CITY HEALTH DEPARTMENT	
M.E. CASE NO.		Registered No. 65 8285	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
Schmitt, Leonard G.		August 9, 1965 2:10P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
St. Joseph Hospital		Maryland	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
		Baltimore 21234 Balto	
		D. STREET ADDRESS (If rural, give location)	
		1226 Halstead Rd. 53-00	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
Male	White	Married	March 16, 1915 50
9. AGE (In years lost birthday)		10. CITIZEN OF WHAT COUNTRY?	
50		USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Supervisor		Baltimore, Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Frank C. Schmitt		Anna L. Stein	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
yes WW 2		212032570	
17. INFORMANT		ADDRESS	
Agnes J. Schmitt		same	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Recto-sigmoid carcinoma with wide spread metastasis	
ANTECEDENT CAUSES		(B) DUE TO	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19		No	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 21, 1965 to August 9, 1965, that (I) (we) last saw the deceased alive on August 9, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
Benjamin V. del Carmen M.D.		August 9, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Benjamin V. del Carmen, M.D.		1400 N. Caroline St., Baltimore, Maryland 21213	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	8-12-65	Gardens of Faith Cem.	Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
AUG 9 1965	Robert E. Farkley, M.D.	Leonard J. Ruck Inc	Baltimore, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 8286		CERTIFICATE OF DEATH				Registered No. 65 8286			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) GARDINER, Lillian Augusta					2. DATE AND HOUR OF DEATH Aug. 6, 1965 6:40 P M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st Street					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 28 D. STREET ADDRESS (If rural, give location) 225 Hilton Ave				
5. SEX Fem	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Sing.	8. DATE OF BIRTH Mar-23, 1901	9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SR. Nurse Officer		10B. KIND OF BUSINESS OR INDUSTRY USPHS Hdq. Wash. D.C.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Francis X. Gardiner			14. MOTHER'S MAIDEN NAME Lillian A. Mudd						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) PHS 1945 to 1958		16. SOCIAL SECURITY NO. 577 54 0698		17. INFORMANT ADDRESS Records USPHS Hospital Baltimore, Md.					
18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the breast ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH months		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					(B) DUE TO				
					(C) DUE TO				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 3 19 65 to August 6 19 65 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 6 19 65 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.									
23A. SIGNATURE Thomas J. Lau					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/7/65		
23C. PHYSICIAN'S NAME (Type) Thomas J. Lau, Surgeon					23D. ADDRESS USPHS Hospital, Baltimore, Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/10/1965		24C. NAME of CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.					



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PHILIP N. TRENCHARD

2. DATE AND HOUR PRONOUNCED DEAD

August 5, 1965 6:45 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3221 Abell Avenue

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3221 Abell Avenue

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

Jan. 2, 1910

9. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Plumber

10B. KIND OF BUSINESS OR INDUSTRY

Plumbing

11. BIRTHPLACE (State or foreign country)

Chestertown, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

G.P. Nesbitt Trenchard

14. MOTHER'S MAIDEN NAME

Nannie C. Dixon

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

16. SOCIAL
SECURITY NO.

218-01-0014

17. INFORMANT

ADDRESS

James D. Trenchard, 4648 Pimlico Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
(If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenacker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
8-6-6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/9/1965

23C. NAME of CEMETERY or CREMATORY

New Cathedral

23D. LOCATION

(City, town, or county)

Baltimore,

Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 9 1965

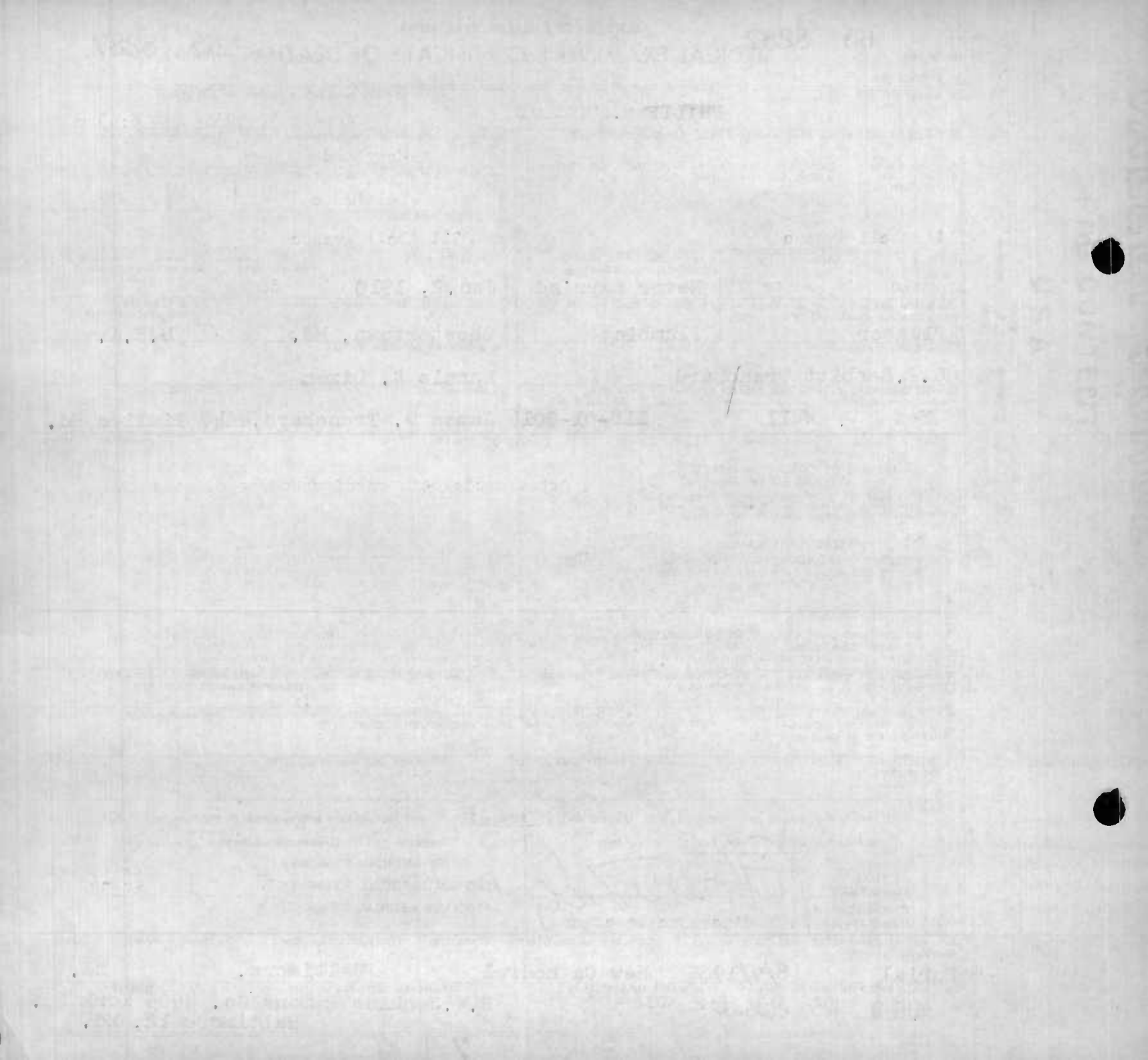
24B. NAME OF REGISTRAR

Robert E. Jenkins

24C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd.

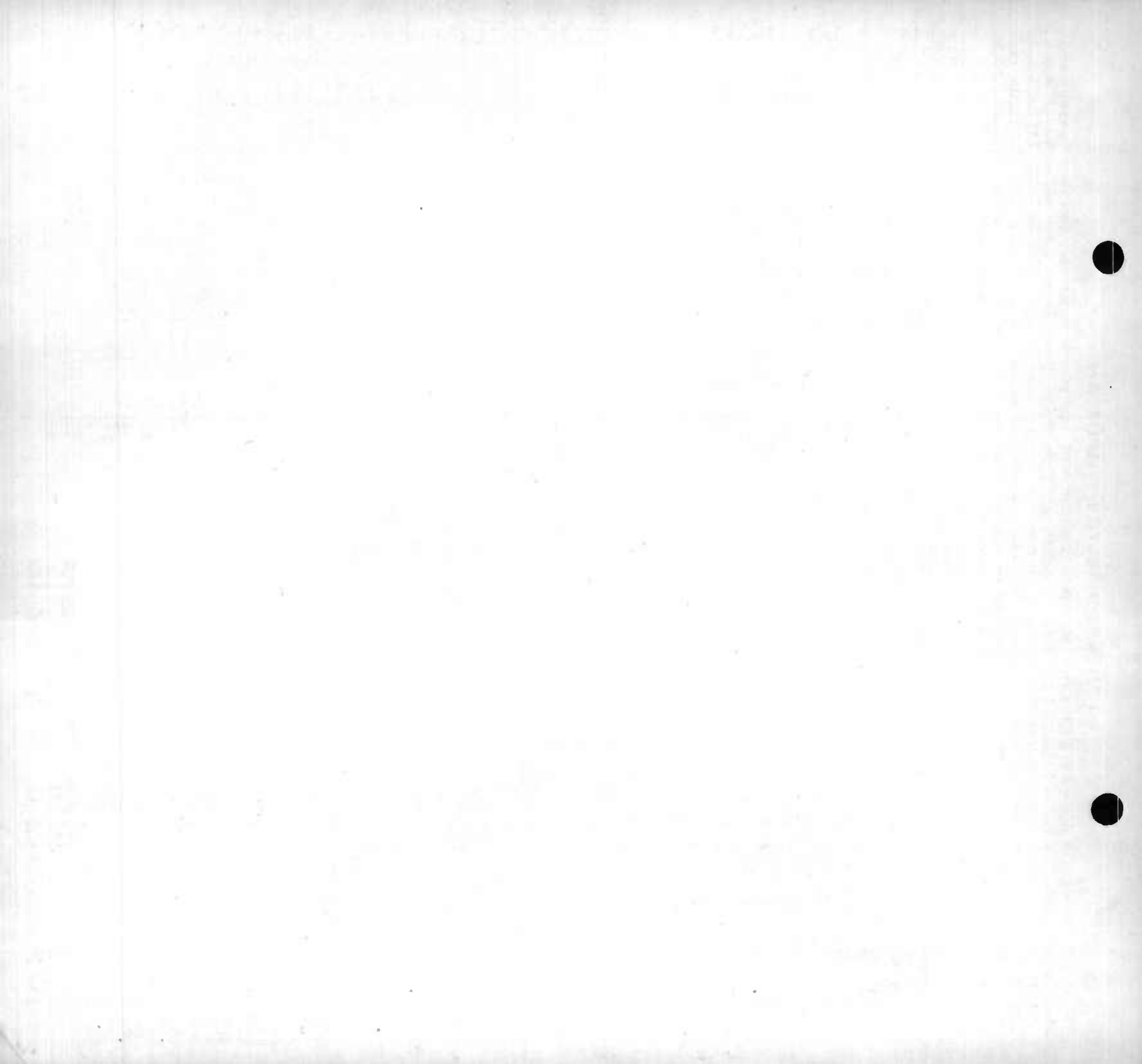
Baltimore 12, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

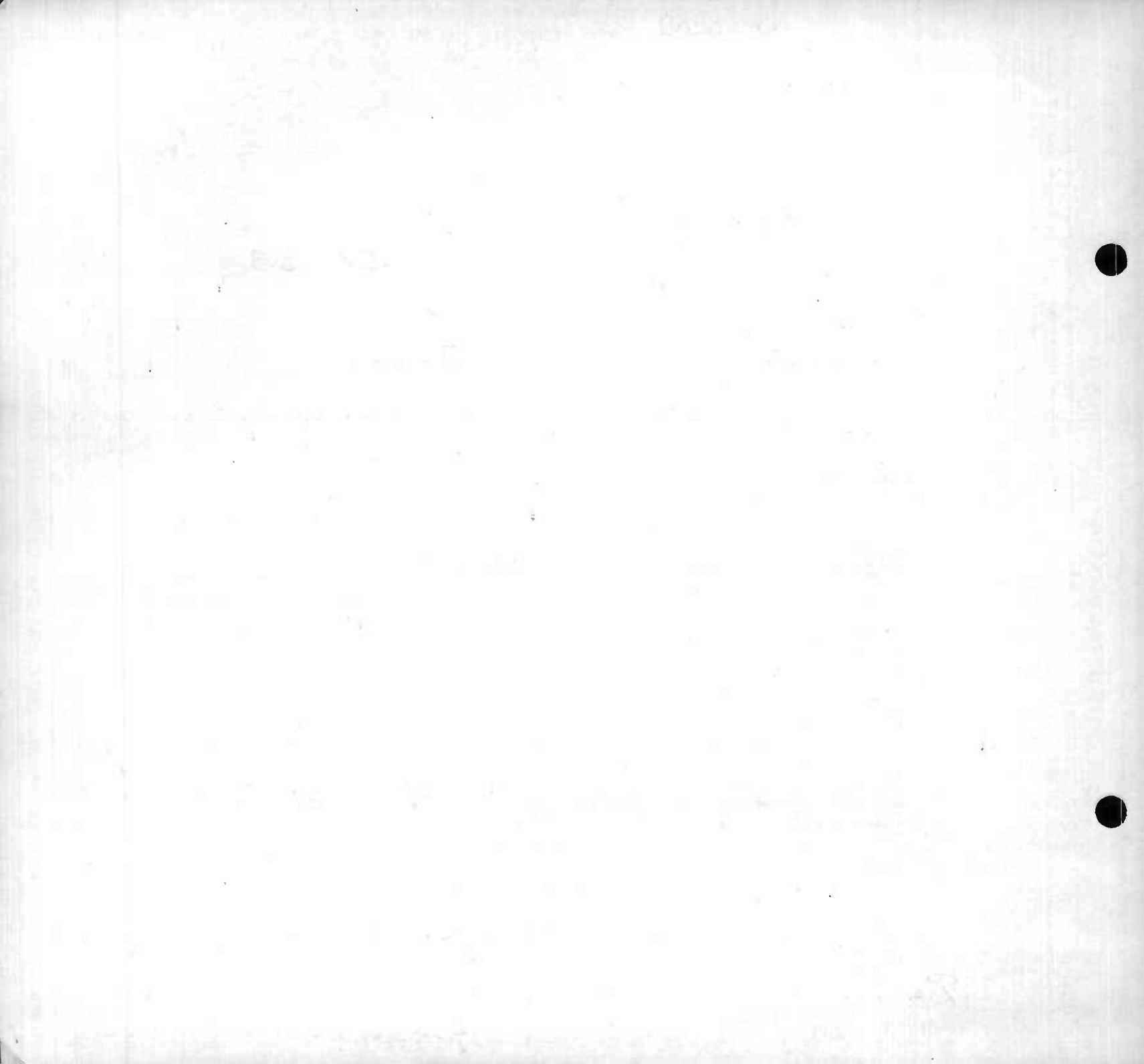
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 8288					CERTIFICATE OF DEATH			Registered No. 8288	
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) SYLVIA K. GRACE					2. DATE AND HOUR OF DEATH 8/4/65 4:30 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL					A. STATE Md. B. COUNTY BALTIMORE 25-05				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 25,				
					D. STREET ADDRESS (If rural, give location) 3811 TENTH ST.				
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW		8. DATE OF BIRTH 12/26/08		9. AGE (In years last birthday) 56	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MASS.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JOHN MATSON					14. MOTHER'S MAIDEN NAME SENJA LAHNANEN				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. -		17. INFORMANT ADDRESS PATIENT-ADMISSION RECORD				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 237X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					CAUSE OF DEATH (A) CEREBRAL EDEMA DUE TO (B) POST-OP. RT. PARIAL BRAIN TUMOR DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH 8/2/65 2 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 3 8/2/65			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BRAIN TUMOR			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) -			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? -			
22. I certify that (X) (this hospital) attended the deceased from 7/28 19 65 to 8/4 19 65, that (I) (we) last saw the deceased alive on 8/4 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE Ivan L. Butler					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 8/4/65	
23C. PHYSICIAN'S NAME (Type) IVAN L. BUTLER					23D. ADDRESS UNIVERSITY HOSP.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 9, 1965		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965			25B. NAME OF REGISTRAR Robert E. Fairbank			25C. FUNERAL DIRECTOR George J. Gonce, 4001 Ritchie Hwy. Baltimore 25, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8289		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8289	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Margaret Morgan</i>		2. DATE AND HOUR OF DEATH <i>8-9-65</i> <i>2:50</i> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>16-01</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>John Hopkins Hospital</i>		D. STREET ADDRESS (If rural, give location) <i>1015 Arlington Ave.</i>		E. AGE (In years last birthday) <i>63</i>	
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>8-25-01</i>	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
11. BIRTHPLACE (State or foreign country) <i>Va</i>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Ape Knight</i>	
14. MOTHER'S MAIDEN NAME <i>Jenny</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Earl Morgan</i>		ADDRESS <i>1015 Arlington Ave.</i>		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Shock</i>	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>2:50 P 8/9 1965</i> to <i>2:50 P 8/9 1965</i> , that (I) (we) last saw the deceased alive on <i>2:50 P 8/9 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>B. K. Gray, M.D.</i>		23B. DATE SIGNED <i>8/9/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>BARRY K. GRAY</i>		23D. ADDRESS <i>Johns Hopkins Hospital</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	
24B. DATE <i>8-12-65</i>		24C. NAME of CEMETERY or CREMATORY <i>pot Aubryn Cem.</i>		24D. LOCATION (City, town, or County) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 9 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Carter, M.D.</i>		25C. FUNERAL DIRECTOR <i>George A. Kline</i>	
25D. ADDRESS <i>1348 N. Calhoun St.</i>					



1

65 8290

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 8290

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE HOGGE

2. DATE AND HOUR PRONOUNCED DEAD

August 6, 1965 1:55 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6204 Fairdel Avenue

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Aug. 7, 1905

9. AGE (In years
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Produce Dept.

10B. KIND OF BUSINESS OR INDUSTRY

Armour & Co.

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Hogge

14. MOTHER'S MAIDEN NAME

Lucy Ransome

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

214-03-1222

17. INFORMANT

ADDRESS

Ethel Hogge-6204 Fairdel Avenue

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-6-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-8-65

23C. NAME OF CEMETERY or CREMATORY

Moreland Memorial

23D. LOCATION

(City, town, or county)

Balto. Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 9 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

John C. Miller Inc. - 6415 Belair Rd.

ADDRESS

WALTER H. HARRIS

W. H. HARRIS

W. H. HARRIS

W. H. HARRIS

W. H. HARRIS

FUNERAL DIRECTOR: IMPORTANT

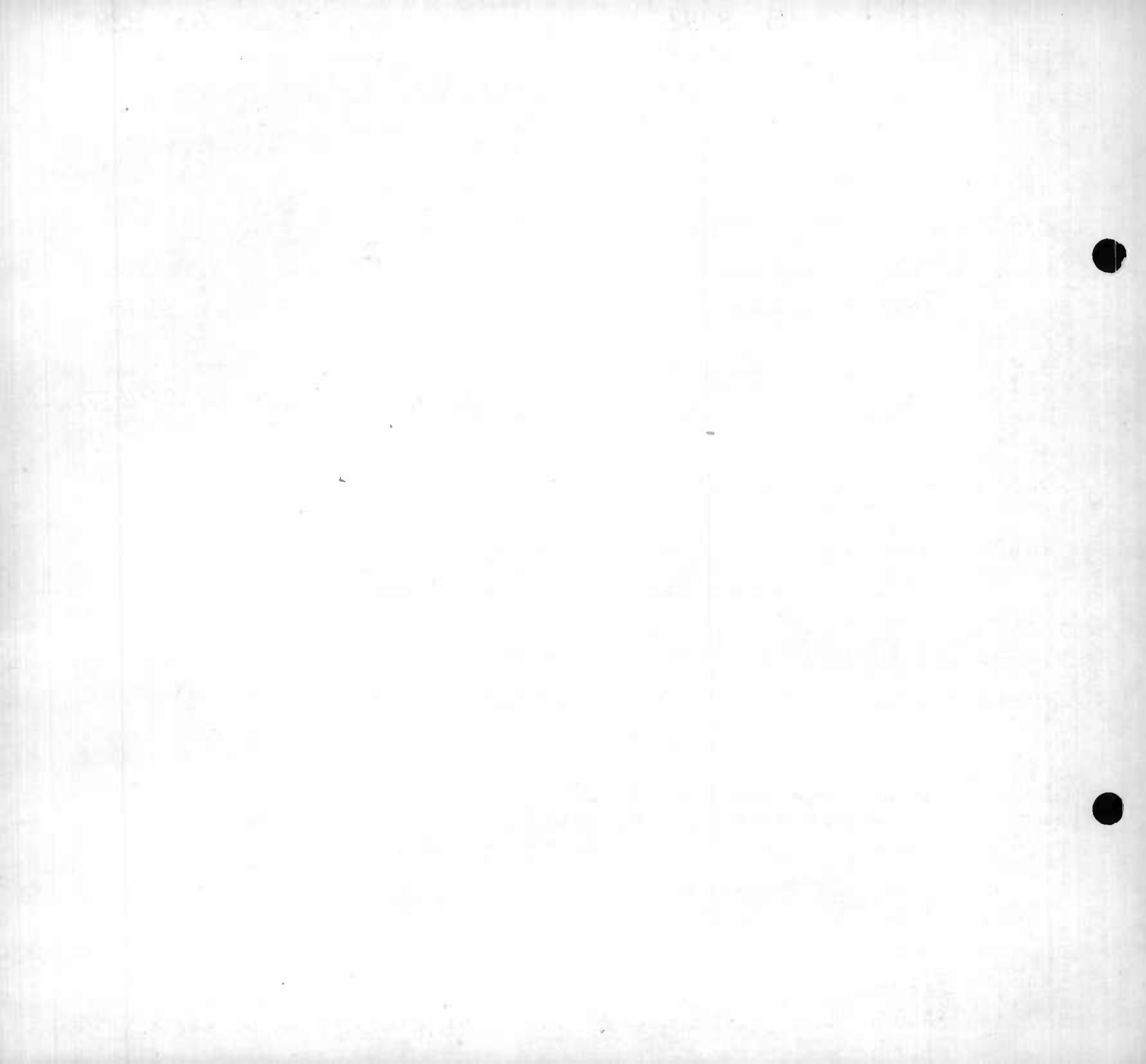
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8291				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8291	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Frey, Frances Lillian		August 3, 1965 1:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
F. NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
St. Joseph Hospital				Maryland		26-01	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore 21206			
				D. STREET ADDRESS (If rural, give location)			
				4202 Belmar Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Female	White	Married	June 2, 1922	43	Homemaker	Baltimore, Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Louis Teller				Theresa Saltysiak			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				216-16-2081		Frederick H. Frey-4202 Belmar Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)				(A) Carcinoma of breast with wide extensive spread metastasis.			
				(B) DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 28, 19 65 to August 3, 19 65, that (I) (we) lost saw the deceased alive on August 3, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Benjamin V. del Carmen M.D.				August 3, 1965			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Benjamin DelCarmen, M.D.				1400 N. Caroline St., Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8-7-65		Holy Redeemer Cemetery		Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 9 1965		Robert E. Taylor		John C. Miller Inc.		6415 Belair Rd.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8292	
BIRTH NO. 65 8292		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED STANISLAUS STANIELAUS GOLEMBIJSKI		2. DATE AND HOUR OF DEATH 8/6/65 7:05 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND B. COUNTY 1-05			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE			
D. STREET ADDRESS (If rural, give location)		329 S. CHESTER STREET			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 5/10/82	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
TAVERN OWNER		RETIRED		POLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
UNKNOWN		UNKNOWN		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		216-18-4293		VICTORIA GOLEMBIJSKI, 329 S. CHESTER ST.	
18. 293X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Ischemia of Arterioles Atherosclerotic Cardiovascular Disease			
		(B) DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
NONE					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NONE		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/5 1965 to 8/6 1965, that (I) (we) last saw the deceased alive on 8/6 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John M. Sabundays		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Aug. 6, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		8/10/65		HOLY ROSARY CEMETERY	
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 9 1965		Robert E. Stankovich		JOHN M. SABUNDAYS INC 401 S CHESTER ST	
24D. LOCATION (City, town, or county) (State)		BALTIMORE C. MD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8293	
BIRTH NO. 65 8293		CERTIFICATE OF DEATH			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) JUANITA WEBER			2. DATE AND HOUR OF DEATH 8-7-65 6:00 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md B. COUNTY Fcy		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME & HOSPITAL			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 831 S. MONTFORD AVE		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1926	9. AGE (In years lost birthday) 39	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10B. KIND OF BUSINESS OR INDUSTRY AMERICAN CAN CO		11. BIRTHPLACE (State or foreign country) W. VA.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME LUTHER MOONEY			14. MOTHER'S MAIDEN NAME WINNIE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 10		17. INFORMANT EDWARD WEBER 831 S. MONTFORD AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PULMONARY EDEMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. LIVER CIRRHOSIS II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH PULMONARY EDEMA LIVER CIRRHOSIS		INTERVAL BETWEEN ONSET AND DEATH YEAR
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on DEAD ON ARRIVAL and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ephraim B. Barzaga M.D.				23B. DATE SIGNED 8/8/65	
23C. PHYSICIAN'S NAME (Type) Ephraim B. BARZAGA		23D. ADDRESS CHURCH HOME & HOSPITAL - BALTD. 31, md			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 8-11-65	24C. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEM		24D. LOCATION (City, town, or county) (State) BALTIMORE MD	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1965		25B. NAME OF REGISTRAR John W. Weber		25C. FUNERAL DIRECTOR JOHN W. WEBER & SONS INC. 401 S. CHESTER ST.	

1. The first part of the report is a general
 description of the area. It is a small
 area, about 100 acres in size, and is
 located in the north-east corner of the
 estate. It is a very fertile area, and
 is used for the purpose of growing
 crops. The crops are mostly of the
 cereals, and are grown in rows. The
 area is very well watered, and the
 crops are very healthy. The first part
 of the report is a general description
 of the area. It is a small area, about
 100 acres in size, and is located in the
 north-east corner of the estate. It is a
 very fertile area, and is used for the
 purpose of growing crops. The crops are
 mostly of the cereals, and are grown in
 rows. The area is very well watered, and
 the crops are very healthy.

The second part of the report is a
 description of the crops. It is a small
 area, about 100 acres in size, and is
 located in the north-east corner of the
 estate. It is a very fertile area, and
 is used for the purpose of growing
 crops. The crops are mostly of the
 cereals, and are grown in rows. The
 area is very well watered, and the
 crops are very healthy.

The third part of the report is a
 description of the crops. It is a small
 area, about 100 acres in size, and is
 located in the north-east corner of the
 estate. It is a very fertile area, and
 is used for the purpose of growing
 crops. The crops are mostly of the
 cereals, and are grown in rows. The
 area is very well watered, and the
 crops are very healthy.

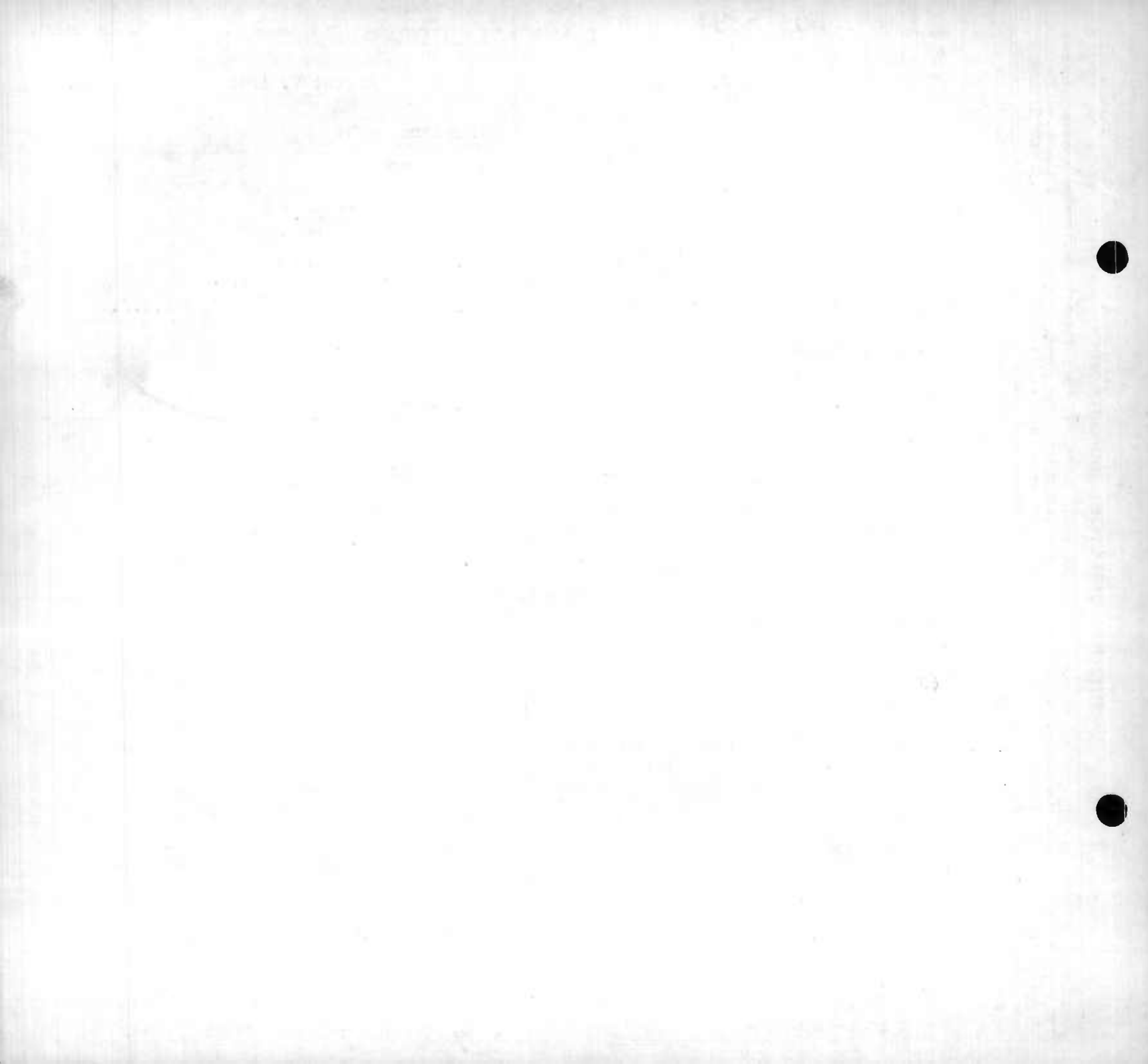
The fourth part of the report is a
 description of the crops. It is a small
 area, about 100 acres in size, and is
 located in the north-east corner of the
 estate. It is a very fertile area, and
 is used for the purpose of growing
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 cereals, and are grown in rows. The
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The fifth part of the report is a
 description of the crops. It is a small
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 crops. The crops are mostly of the
 cereals, and are grown in rows. The
 area is very well watered, and the
 crops are very healthy.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8294	
BIRTH NO. 65 8294		CERTIFICATE OF DEATH			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) James J. Cawley			2. DATE AND HOUR OF DEATH August 7, 1965 5 A.M. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6735 O'Donnell St.			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 6735 O'Donnell St.		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH July 3, 1908	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane operator		10B. KIND OF BUSINESS OR INDUSTRY Steel	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James J. Cawley			14. MOTHER'S MAIDEN NAME Margaret Moran		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mrs. Catherine Cawley 6735 O'Donnell St.		
18. 150X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Carcinoma of esophagus ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs
19A. DATE OF OPERATION 0 1964		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of esophagus		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1963 to Aug. 19 65 , that (I) (we) last saw the deceased alive on July 14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B.W. Sollod M.O.			23B. DATE SIGNED 8-9-65		
23C. PHYSICIAN'S NAME (Type) B.W. Sollod M.O.			23D. ADDRESS 2900 Duncan Road		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/10/65	24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Colgate, Md.
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Ulrich Funeral Home Dundalk, Md.	



US: 43-71-701

65 8295

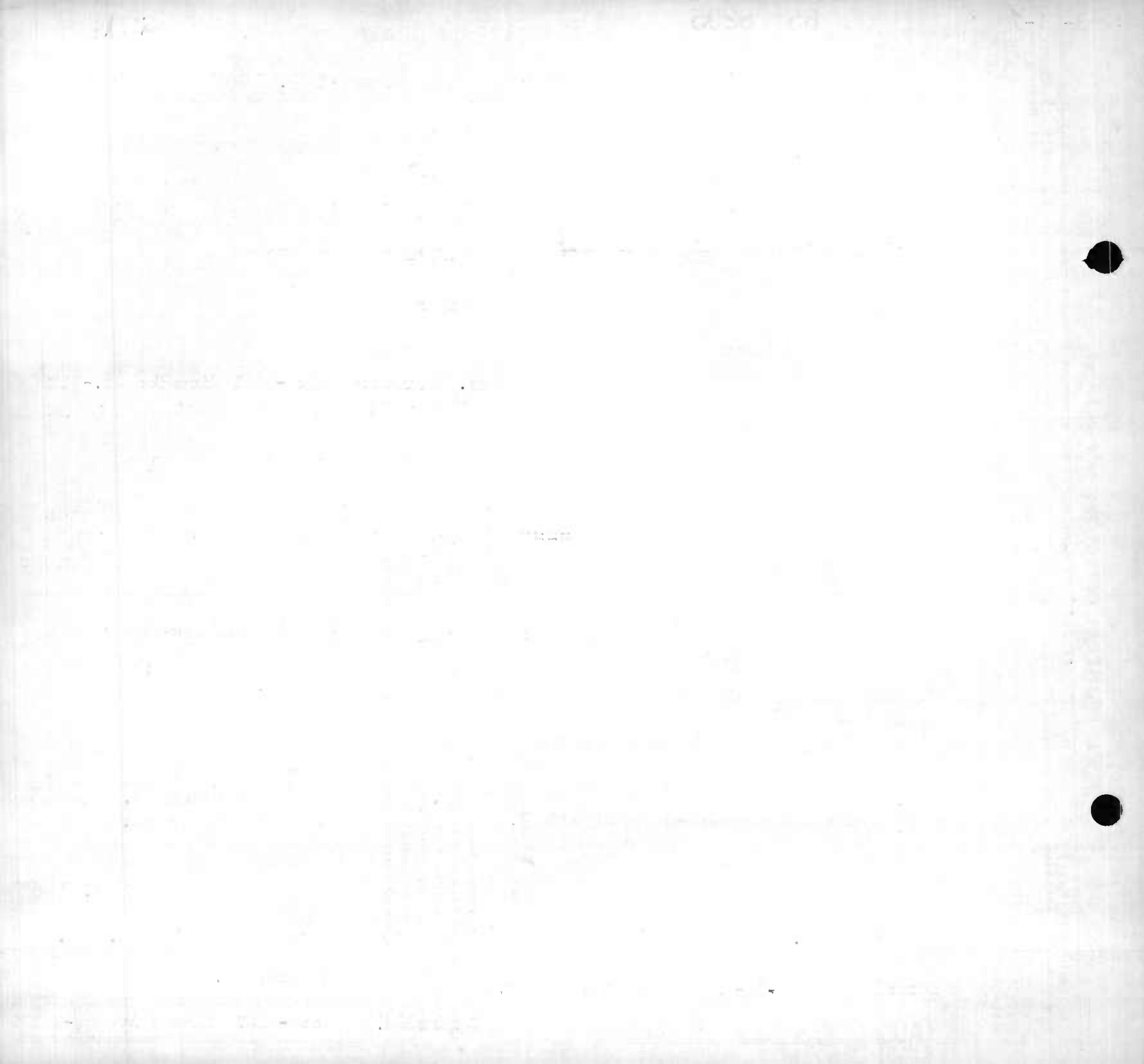
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 8295

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Margaret Kremer		August 9, 1965 5:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224				Maryland Baltimore			
5. SEX				6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
Female		White		single		widowed	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
4-12-84		81				Maryland	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				12. CITIZEN OF WHAT COUNTRY?			
None							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
unknown				unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				Mrs. Henrietta Smith-1141 Wicomico St.-21230 RECORDS: BCH: 4940 Eastern Avenue			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
I				Staphylococcal Septicemia		1 Week	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Decubitus Ulcers (Severe Multiple) Months			
				(C) (L) Cerebral Vascular Accident With (R) Hemiparesis		5 Months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Cholelithiasis- Jaundice (Obstructive) 4 Months			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				Yes		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from May 28, 19 65 to August 9, 19 65, that (I) (we) last saw the deceased alive on August 9, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Dr. David Curtiss				August 9, 1965			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Dr. David Curtiss		4940 Eastern Avenue Baltimore, Md. #24		Burial		8-11-65	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
Western Cemetery		Baltimore, Md.		AUG 11 1965		Robert E. Finkbeiner	
25C. FUNERAL DIRECTOR		25D. ADDRESS		25E. DATE REC'D BY HEALTH DEPT.		25F. NAME OF REGISTRAR	
Howard H. Hubbard		4107 Wilkens Avenue-21229		AUG 11 1965		Robert E. Finkbeiner	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 8296		CERTIFICATE OF DEATH		65 8296	
1. NAME OF DECEASED (Type or Print) HARRIS LAURA M			2. DATE AND HOUR OF DEATH 1:45 AM 8/7/65		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GEN. HOSP.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto D. STREET ADDRESS (If rural, give location) Sutton Place 1111 Park Ave APT 1114		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MFS	8. DATE OF BIRTH 11/25/24	9. AGE (In years last birthday) 40	10. Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY SEC FOR HARRIS AUTO SUPPLY		11. BIRTHPLACE (State or foreign country) W VA	
13. FATHER'S NAME CANADAY WENTON			14. MOTHER'S MAIDEN NAME SALLY COOPER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 236 36 0783		17. INFORMANT Husband ADDRESS Same	
18. 5-41.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ASPIRATION OF PNEUMONIC GASTRIC CONTENTS BLEEDING DUOD-ULCER			INTERVAL BETWEEN ONSET AND DEATH 2 HOURS		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) C.H.F. 1 HOUR		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			OPERATION		
19A. DATE OF OPERATION 8/7/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED DUOD ULCER		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/6/65 1965 to 8/7 1965, that (I) (we) last saw the deceased alive on 1:45 AM 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dominic A. Culotta M.D.			23B. DATE SIGNED 8/7/65		23C. PHYSICIAN'S NAME (Type) DOMINIC A. CULOTTA M.D.
23D. ADDRESS MD GEN HOSP			24. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 8/10/65		24C. NAME OF CEMETERY or CREMATORY Garden of Faith		24D. LOCATION (City, town, or county) (State) Balto Co.	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR W. Heumann ADDRESS 6067 Hay Rd	

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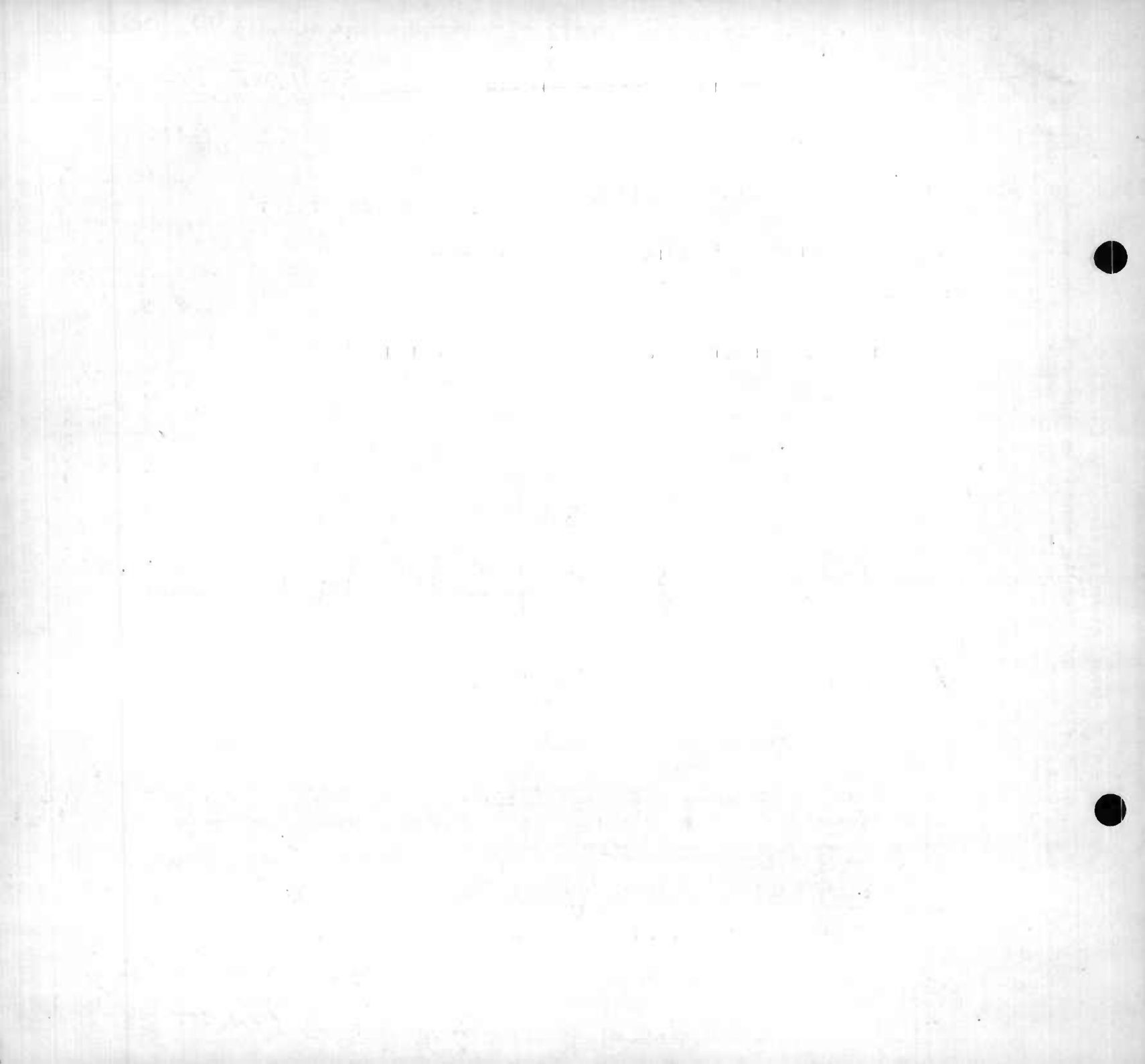
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>93857 78297</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. <u>65 8297</u>	
M.E. CASE NO. <u>93857 78297</u>			1. NAME OF DECEASED (Type or Print) CARRIE RACHELLE WILSON		
2. DATE AND HOUR OF DEATH 5PM DST. 8/3/65			M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY HARFORD C. CITY OR TOWN (If outside city limits, write RURAL and give township) HAVRE DE GRACE D. STREET ADDRESS (If rural, give location) 823 OTSEGO STREET		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) CHILD	8. DATE OF BIRTH 8-8-56	9. AGE (In years lost birthday) 8	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY Student		11. BIRTHPLACE (State or foreign country) Havre de Grace Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILSON, WILLIAM F.		14. MOTHER'S MAIDEN NAME PATRICIA TAYLOR	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Patricia Taylor 823 Otsego St. Havre de Grace Md. 21078	
18. <u>2092.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) (A) Pulmonary edema DUE TO (B) Aplastic Anemia DUE TO (C) Overwhelming sepsis and peritonitis			INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 months 2 weeks		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. none			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none		
19A. DATE OF OPERATION 7/24/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Diaphragmatic abscess/splenectomy		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1965</u> to <u>August 3, 1965</u> , that (I) (we) last saw the deceased alive on <u>August 3 - 5PM 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harrison Dwight Cavanagh				23B. DATE SIGNED 8/3/65 6PM	
23C. PHYSICIAN'S NAME (Type) HARRISON DWIGHT CAVANAGH		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/7/65	24C. NAME OF CEMETERY or CREMATORY Angel Hill Cem.	24D. LOCATION (City, town, or county) (State) Havre de Grace, Md.		
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1965	25B. NAME OF REGISTRAR Robert E. Feltus	25C. FUNERAL DIRECTOR Angel Hill Cem., Havre de Grace, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 8298		CERTIFICATE OF DEATH		Registered No. 65 8298	
1. NAME OF DECEASED (Type or Print) Annette E. Lowinger				2. DATE AND HOUR OF DEATH 8/9/65 12²⁰ P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 Mercy Hosp. Accident Room				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY 28-09					
5. SEX Female 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) DIVORCED				8. DATE OF BIRTH Sept. 29, 1906		9. AGE (In years last birthday) 58		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary				10B. KIND OF BUSINESS OR INDUSTRY Mass. Mutual Ins. Co.		11. BIRTHPLACE (State or foreign country) Vienna, Austria		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Adolph Spielmann				14. MOTHER'S MAIDEN NAME Rachel ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Logan Road Mrs. McKenny Egerton Jr. Owings Mills, Maryland			
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiogenic Shock				CAUSE OF DEATH (A) Cardiogenic Shock DUE TO				INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute posterior myocardial inf.				(B) Acute posterior myocardial inf. DUE TO				1 hr.	
(C) Complete heart block.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 8/9 1965 to 8/9 1965 , that (I) (we) last saw the deceased alive on 8/9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE E. Lee Robbins M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/9/65			
23C. PHYSICIAN'S NAME (Type) E. Lee Robbins M.D.				23D. ADDRESS Mercy Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/10/65		24C. NAME of CEMETERY or CREMATORY Baltimore Hebrew Cemetery		24D. LOCATION (City, town, or county) (State) Reisterstown, Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1965		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Sol Levinson & Bros.		ADDRESS 6010 Reisterstown Road			

3

22/10/73

E Lee R. P. 22

65 8299

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65 8299

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HARRY SILVER

2. DATE AND HOUR PRONOUNCED DEAD

8/9/65 1:00 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4526 Pimlico Rd.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

12/24/1889 75

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cutter

10B. KIND OF BUSINESS OR INDUSTRY

Clothing

11. BIRTHPLACE (State or foreign country)

Latvia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

Yes

W. W. 1

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Frieda Silver- 4526 Pimlico Road

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Arteriosclerotic cardiovascular disease
DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner H. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/10/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/11/65

23C. NAME OF CEMETERY or CREMATORY

Bnai Israel

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

AUG 11 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Sol Levinson & Bros Inc. 6010 Reisterstown Rd

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8300		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8300	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Kellert, Annie		2. DATE AND HOUR OF DEATH 8/9/65 9 19:25 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hospital of Baltimore		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-10 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) LEVINDALE Nursing Home. (21215).			
5. SEX Female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widow	8. DATE OF BIRTH 12/12/82	9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Elliott Rosenheim		14. MOTHER'S MAIDEN NAME Baila ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Evelyn Goldman 3610 Glen Avenue	
18. 493X+260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE.		CAUSE OF DEATH (A) PNEUMONIA DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 18 Days.	
19A. DATE OF OPERATION July 30, 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Tracheostomy for Atelectasis		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO.		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?					
22. I certify that (this hospital) attended the deceased from July 30, 1965 to August 9, 1965, that (I) lost saw the deceased alive on August 9, 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE Alan G. Corman		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 9, 1965	
23C. PHYSICIAN'S NAME (Type) ALAN G. CORMAN		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/11/1965		24C. NAME OF CEMETERY or CREMATORY Beth Tfiloh	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. AUG 11 1965			
24F. NAME OF REGISTRAR Robert E. Taylor		24G. FUNERAL DIRECTOR Sol Levinson & Bros. 6010 Reisterstown Road			

USA

At Home

Houswife

Bella ?

Elliott Rosenheim

Mrs. Evelyn Goldman 3610 Glen Avenue

FUNERAL DIRECTOR: IMPORTANT

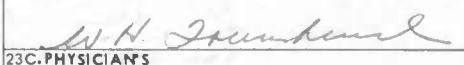

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

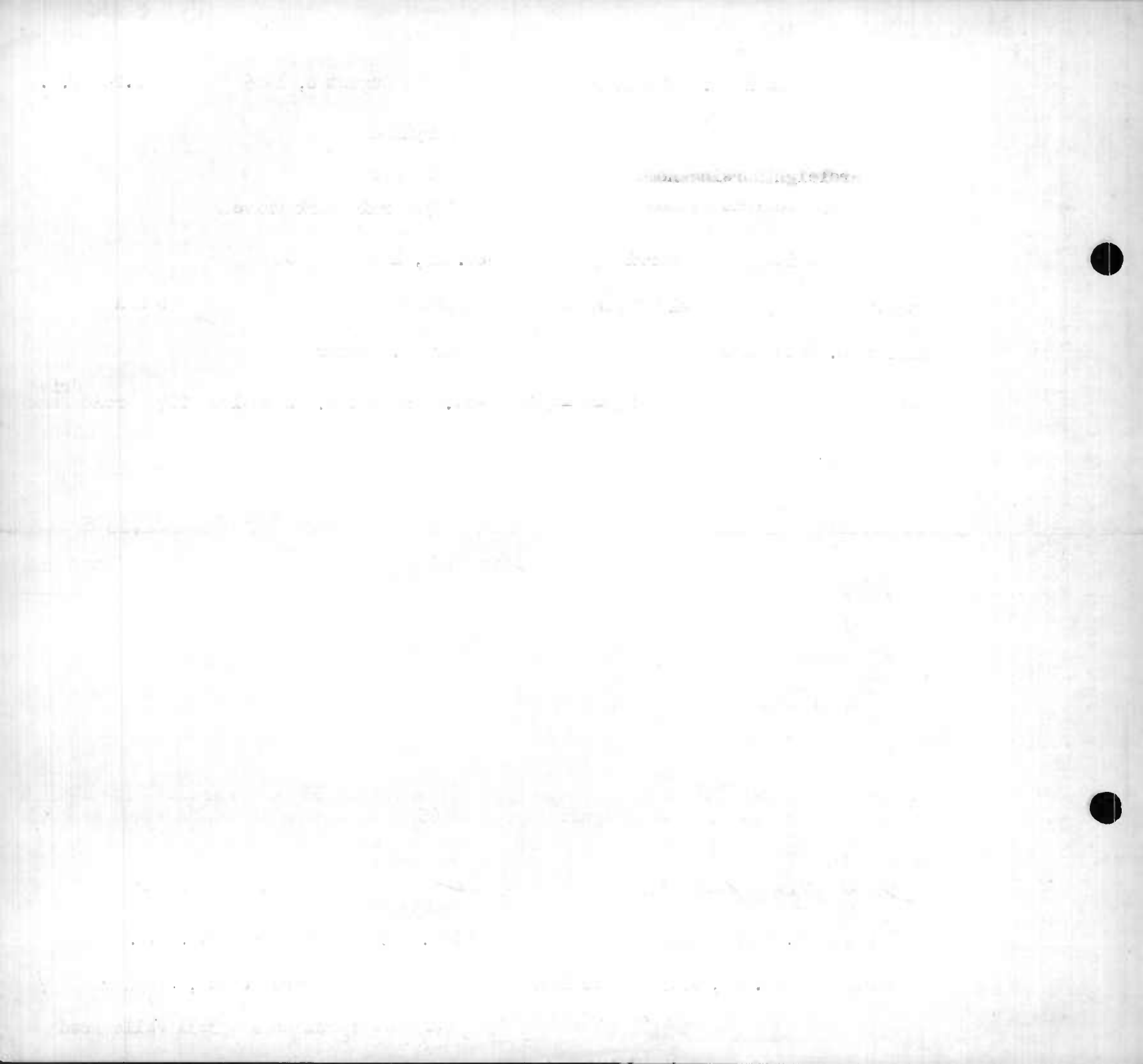
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8301	
BIRTH NO. 65 8301		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Charles H. Raftery		2. DATE AND HOUR OF DEATH 8/10/65 10:30 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1253 Light St.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2302 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1515 Patapsco St.		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Dec. 13, 1888	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Oil Co.		11. BIRTHPLACE (State or foreign country) Balto. Md.	
13. FATHER'S NAME Patrick Raftery			14. MOTHER'S MAIDEN NAME Mary Ellen Sheridan		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes # 1		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Margaret Nagel 1515 Patapsco St.	
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Carcinoma of Lung DUE TO (B) DUE TO (C)		
INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 19 65 to Aug 10 1965 , that (I) (we) lost saw the deceased alive on Aug 10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. L. Loya M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 8/10/65	
23C. PHYSICIAN'S NAME (Type) RICHARDO LOZADA				23D. ADDRESS 1228 S. Chase St. Balto. 39, 14	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8 13 65		24C. NAME of CEMETERY or CREMATORY Balto. U. S. National	
24D. LOCATION (City, town, or county) (State) Balto. Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS 788 Gully 4 130 E. Fort Ave.	

Called Funeral Director
This was a home call.
4.m.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
65 8302					65 8302					
BIRTH NO.					REGISTERED NO.					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Lewis F. Batchelor					2. DATE AND HOUR OF DEATH August 8, 1965 6:20 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND 90 Ardleigh Nursing Home 2095 Rockrose Avenue					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 13-28 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2078 Druid Park Drive					
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Nov. 11, 1884	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days Hours Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer		10B. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A				
13. FATHER'S NAME William L. Batchelor					14. MOTHER'S MAIDEN NAME Mary T. Tucker					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 217-24-4590		17. INFORMANT Mrs. Margaret C. Batchelor				ADDRESS Drive 2078 Druid Park	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 443X1					CAUSE OF DEATH (A) Cerebral Thrombosis DUE TO			INTERVAL BETWEEN ONSET AND DEATH 5 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) Arteriosclerotic Cardiovascular Disease DUE TO			10 Years		
					(C) Hypertension			10 Years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 1955 to Present 19 that (I) (we) last saw the deceased alive on August 8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE 					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 8-10-65		
23C. PHYSICIAN'S NAME (Type) Wilfred H. Townshend					23D. ADDRESS M.D. 14 E. Eager Street - Balto. Md. 21202					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 11, 1965		24C. NAME of CEMETERY or CREMATORY Woodlawn		24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland				
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1965		25B. NAME OF REGISTRAR 			25C. FUNERAL DIRECTOR 7 Bugbee Funeral Home					ADDRESS 3631 Falls Road



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RAYMOND H. SULLIVAN

2. DATE AND HOUR PRONOUNCED DEAD

8/8/65 4:17 a.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

BALTO. CO.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 21228

D. STREET ADDRESS (If rural, give location)

138 N. Symington Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

12/10/06

9. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SALESMAN

10B. KIND OF BUSINESS OR INDUSTRY

ESKAT BAKE PROD.

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

CHARLES W. SULLIVAN

14. MOTHER'S MAIDEN NAME

HATTIE BURKHOLDER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

21203 7540 MRS. MILDRED SULLIVAN

17. INFORMANT

ADDRESS

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/8/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

8/11/65

23C. NAME OF CEMETERY or CREMATORY

LOUPDON PARK

23D. LOCATION

(City, town, or county)

(State)

BALTO, MD.

24A. DATE REC'D BY HEALTH DEPT.

AUG 11 1965

24B. NAME OF REGISTRAR

Robert E. Fidler, M.D.

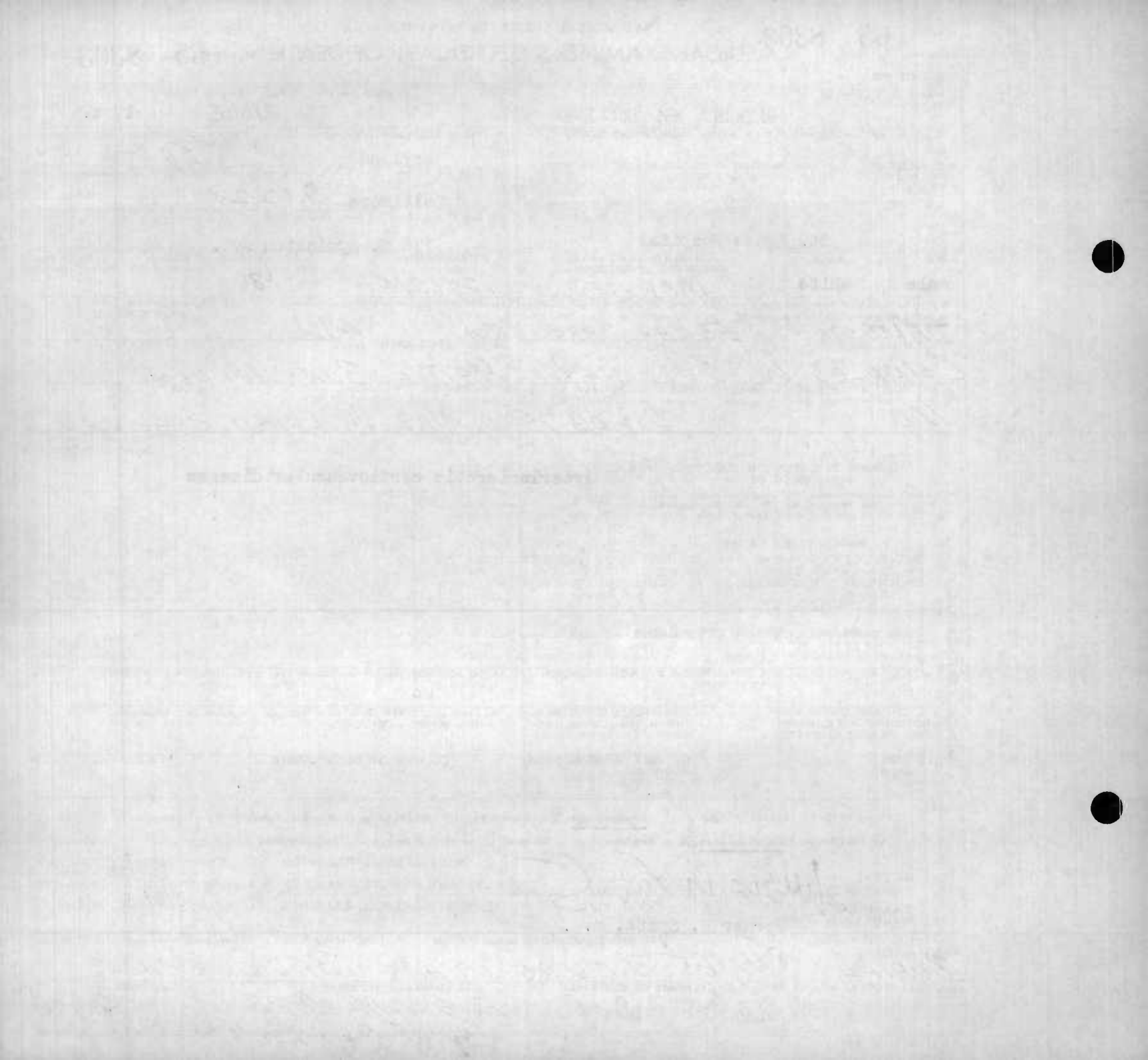
24C. FUNERAL DIRECTOR

E.S. MACNABB

ADDRESS

3718 FREDERICK RD.

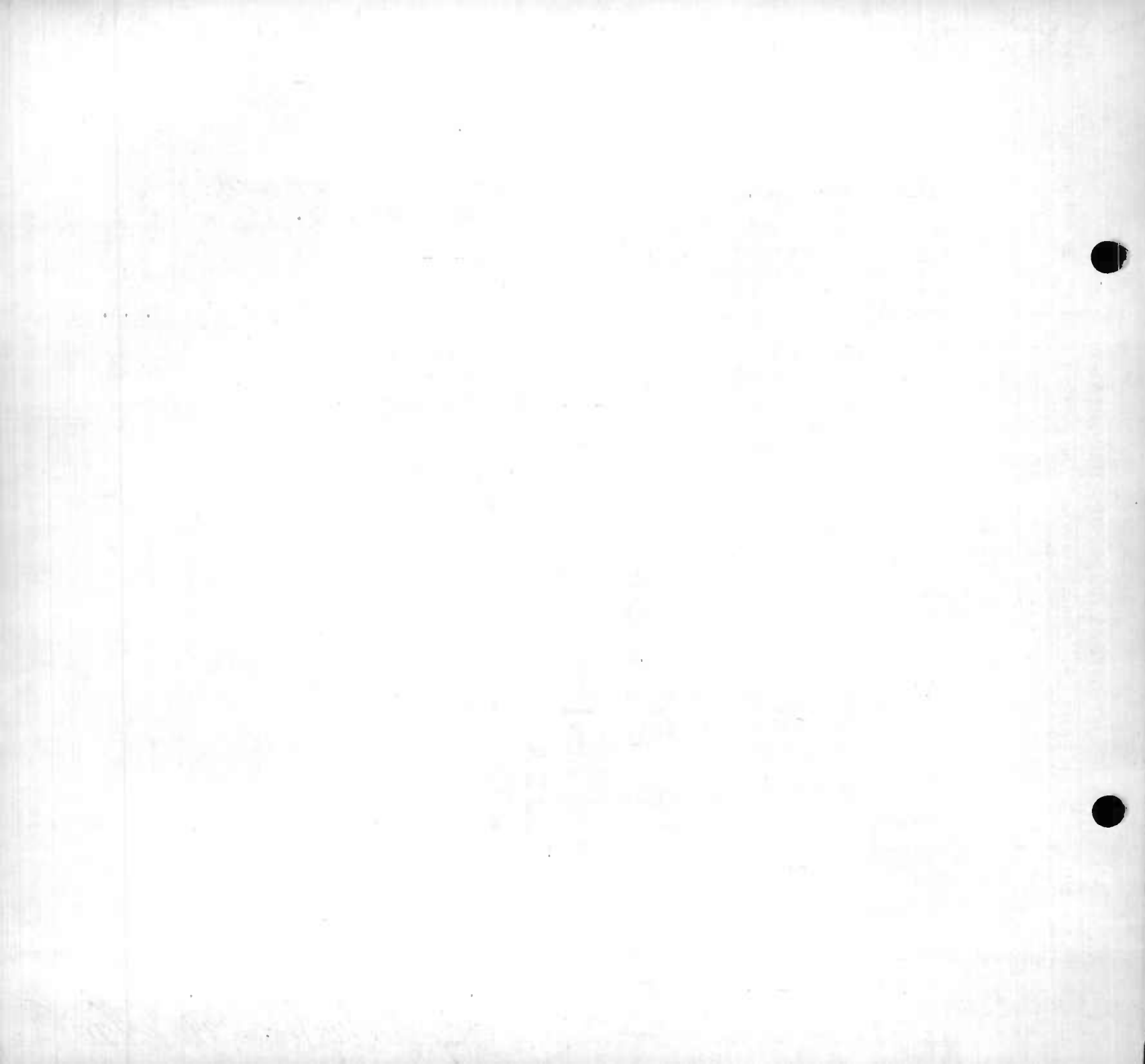
21228



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

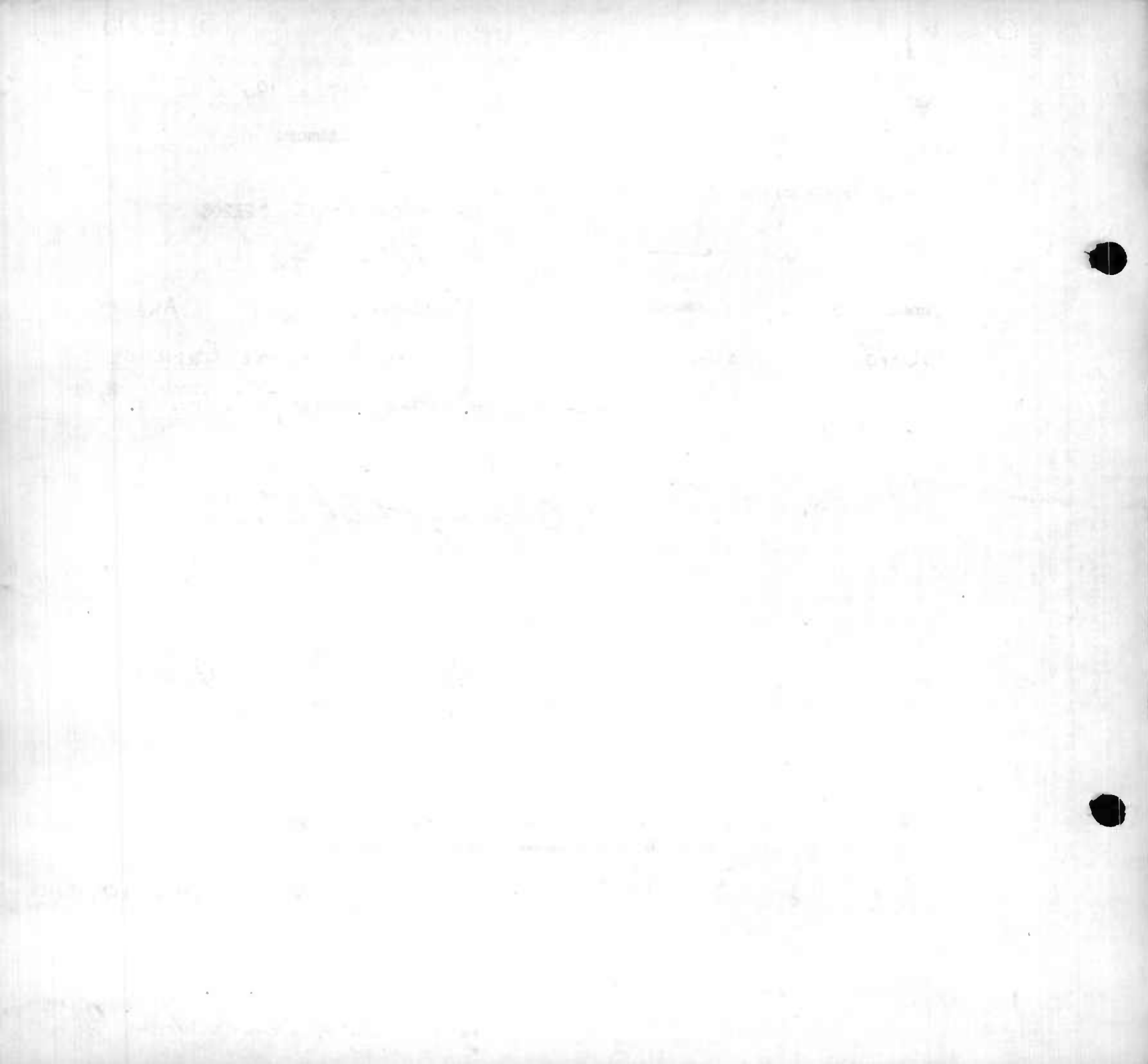
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8304	
BIRTH NO. 65 8304		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) NELL LANE		2. DATE AND HOUR OF DEATH AUGUST 8- 1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4212 PARKMONT AVE.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4212 PARKMONT AVE.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 11-19-1906	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) HINTON, WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN RUDOLPH LANE		14. MOTHER'S MAIDEN NAME ADA GILL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 232-14-8078		17. INFORMANT ADDRESS GERALDINE PERSINGER 2725 MELBOURNE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Ruptured aneurysm of the Aorta (B) Atherosclerosis (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mario E. Comas M.D.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) MARIO E. COMAS		23D. ADDRESS 5101 Belair Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-11-65		24C. NAME of CEMETERY or CREMATORY FORK METHODIST CEM.	
24D. LOCATION (City, town, or county) FORK		(State) MD.		25A. DATE REC'D BY HEALTH DEPT. AUG 11 1965	
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

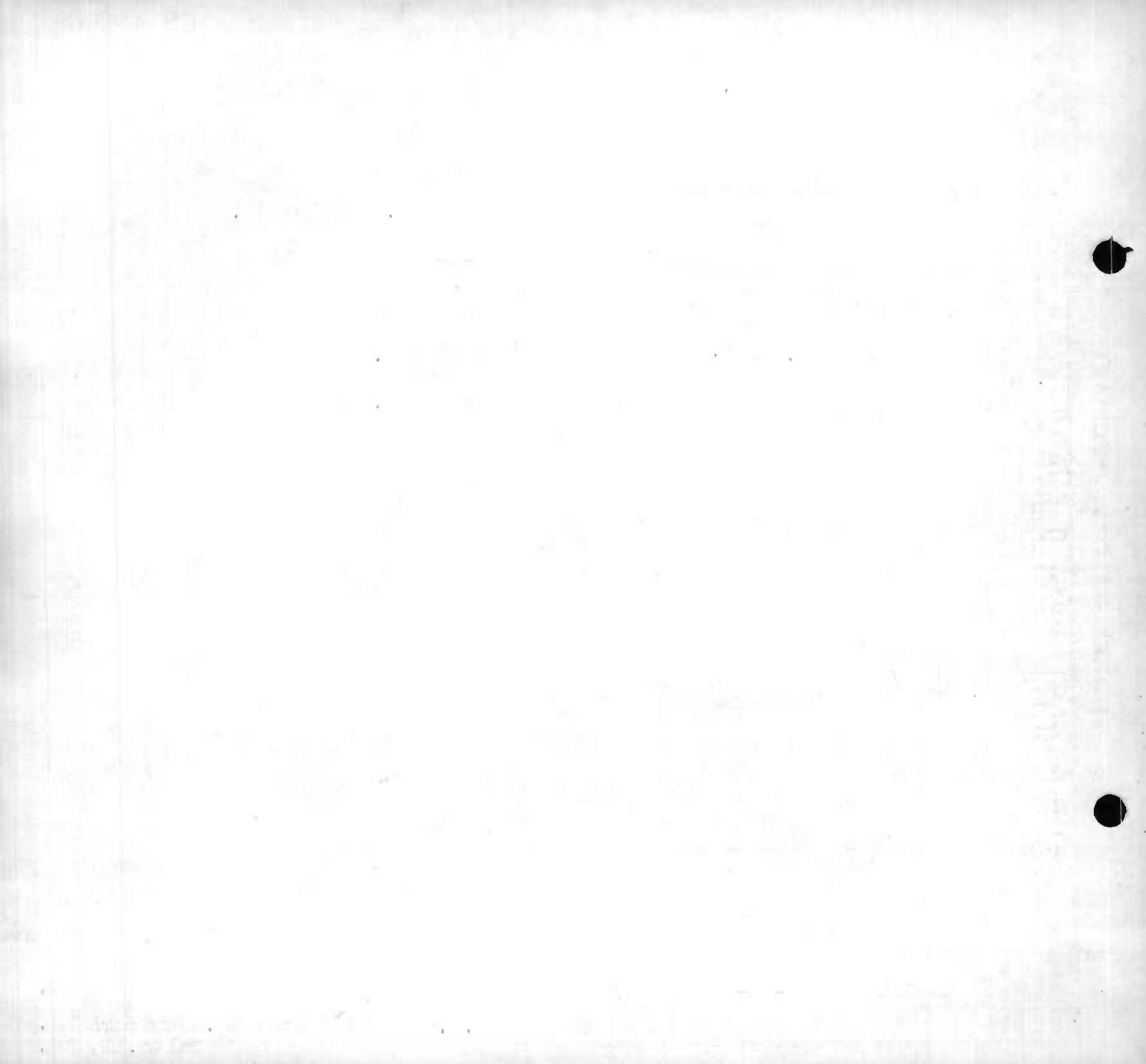
BIRTH NO. 65 8305				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 8305	
M.E. CASE NO. 65 8305				1. NAME OF DECEASED (Type or Print) Ethel Agnes Veise		2. DATE AND HOUR OF DEATH Aug 10, 1965 6:45 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE Md.		B. COUNTY Baltimore City			
Union Memorial Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Pikesville		5300	
				D. STREET ADDRESS (If rural, give location)		16 Salem Court		21208-1108	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 4/24/92	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Homemaker				Baltimore, Maryland		Amer.			
13. FATHER'S NAME George W. Mallonee				14. MOTHER'S MAIDEN NAME Belinda Gertrude Gardner					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216-01-5755		17. INFORMANT ADDRESS Rev. Nelson F. Veise 1701 Thornbury Road Baltimore, Md. 9			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
ACUTE MYOCARDIAL INFARCTION				Crownary thrombosis				See p. 1	
ANTECEDENT CAUSES									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (this hospital) attended the deceased from 8/7/65 to 8/10/65, that (we) last saw the deceased alive on 8/10/65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.									
23A. SIGNATURE J. 3. Han				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Aug. 10, 1965			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
				M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/13/1965		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) Pikesville, Md.		(State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR J. M. J. Tucker & Sons		ADDRESS Balto. Md. with Pa. ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8306		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8306	
M.E. CASE NO.			1. NAME OF DECEASED		
Edna F. Grove			2. DATE AND HOUR OF DEATH		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Children's Hospital			Maryland		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			3900 N. Charles St.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
F	W	Married	4-1-92	73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Own Home		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Frederick G. Gable			Amelia M. Raefeldt		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Roscoe E. Grove Above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			myocardial infarction 48 hours.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
3 7/16		FX Hip		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		HOME		3900 N. CHARLES ST. 12-01	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
7 11 65 10:00 P.M.		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		FALL	
22. I certify that (I) (this hospital) attended the deceased from 7-12 1965 to 8-9 1965, that (I) (we) last saw the deceased alive on 8-9 1965 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
John Ey				8-9-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
John Ey		M.D. Childrens Hospital, 3825 Greenspring Ave			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8-12-65		Woodlawn	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 11 1965		Robert E. Jenkins		H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	

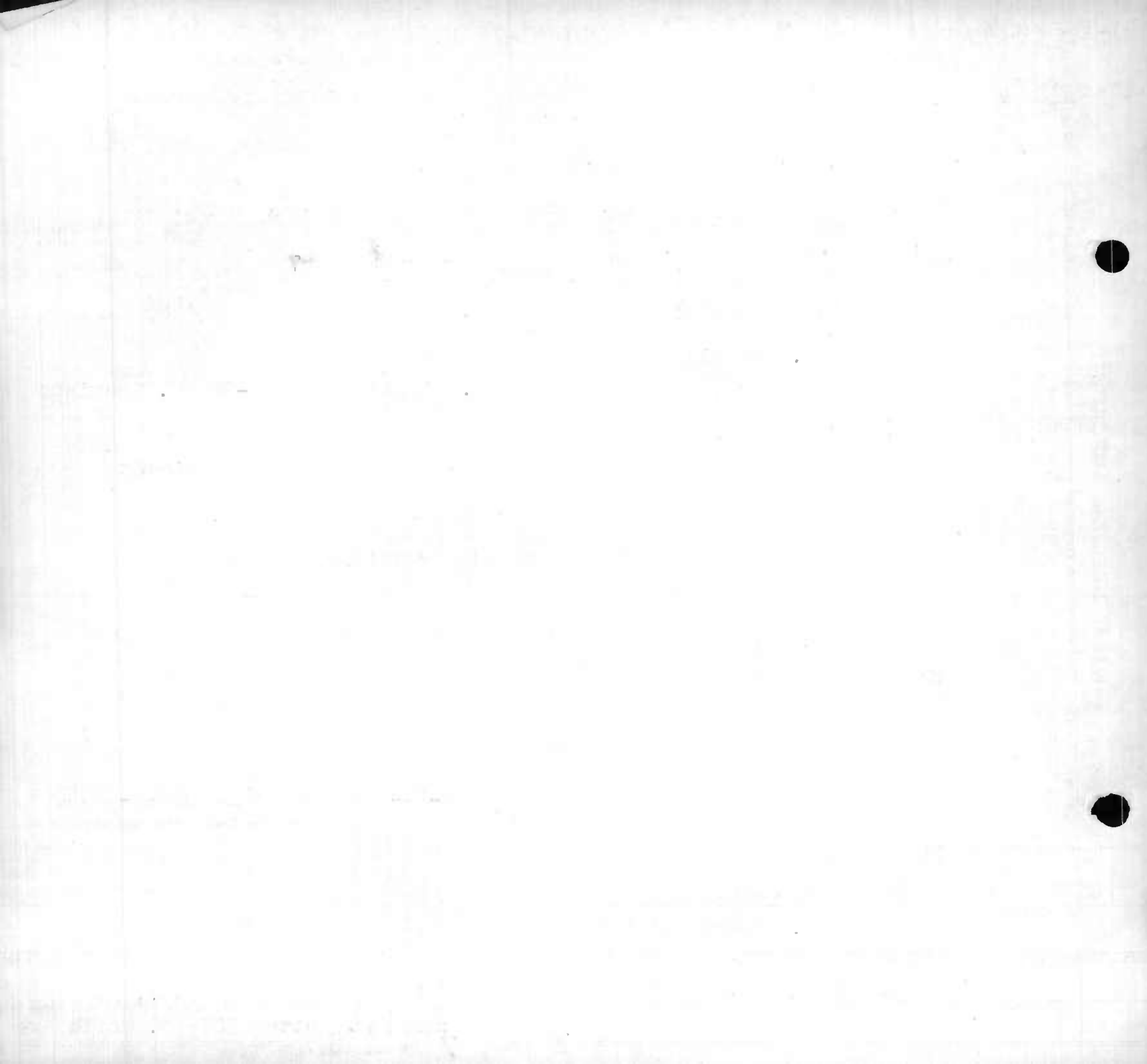


43-89-39:CEK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8307	
T46065 8307		CERTIFICATE OF DEATH			
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		Geneva Taylor		8-9-65 6:45A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland		20-07	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
D. STREET ADDRESS (If rural, give location)		220 North Denison Street 21229			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Female	Negro	Divorced	2-22-98	67	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Domestic		Private Family		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Solomon V. Randall		Mary Robinson		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Mr. William Taylor -220 N. Dennison St RECORDS: BCH: 4940 Eastern Avenue	
18. 260X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) Recent cerebral-vascular accident 2 weeks DUE TO		weeks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Electrolyte imbalance DUE TO		weeks	
		(C) Diabetes mellitus DUE TO		years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Arteriosclerotic heart disease		years	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2		Yes	Yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-17-19 65 to 8-9-19 65, that (I) (we) last saw the deceased alive on 8-9-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Dr. Howard Rathbun				8-9-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		BCH: 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	8/13/65	Arbutus Memorial Park		Baltimore County, Md	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS			
AUG 11 1965	Herbert E. Nutter	3035 W. North Ave			



FUNERAL DIRECTOR: IMPORTANT

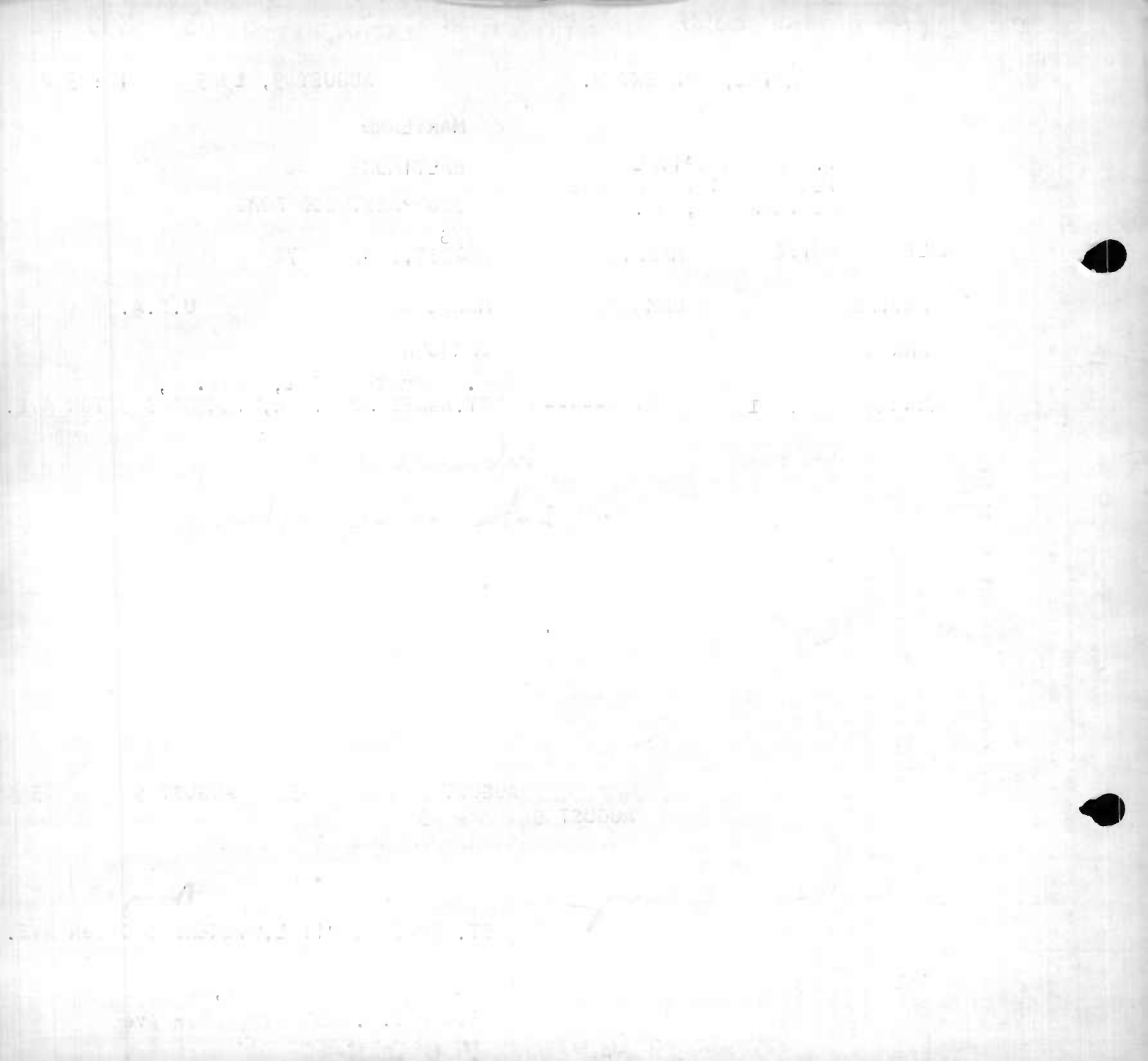
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. 65 8308	
BIRTH NO. H 63665 8308					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Hermine L. H. Hartridge		2. DATE AND HOUR OF DEATH August 8, 1965 8:55 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 14-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 340 Bloom Street			
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH May 19, 1898	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietress		10B. KIND OF BUSINESS OR INDUSTRY Boarding Home		11. BIRTHPLACE (State or foreign country) Richmond Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME John Harlow		14. MOTHER'S MAIDEN NAME Sarah Trent			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-12-0571		17. INFORMANT ADDRESS James E. Hartridge-340 Bloom St.	
18. 442X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Pulmonary Edema - hours		CAUSE OF DEATH (A) DUE TO Congestive Heart Failure - years		INTERVAL BETWEEN ONSET AND DEATH 3 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Hypertensive Cardiovascular disease Unknown			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from July 1965 to August 8, 1965 , that (I) (we) last saw the deceased alive on August 8, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Charles R. Venter		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED August 10, 1965	
23C. PHYSICIAN'S NAME (Type) Charles R. Venter		23D. ADDRESS 2320 Eutaw Place			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/11/65		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland					
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter-3035 W. North Ave	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8309	
BIRTH NO. 65 8309		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED MEINL, HERBERT W.	
2. DATE AND HOUR OF DEATH AUGUST 9, 1965 10:25 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE 29, MD.		A. STATE MARYLAND B. COUNTY BALTO	
5. SEX MALE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 28	
6. RACE WHITE		D. STREET ADDRESS (If rural, give location) 926 PRESTWOOD ROAD	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 7/8 AUGUST, 1893	
9. AGE (In years lost birthday) 72		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		11. BIRTHPLACE (State or foreign country) MARYLAND	
10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 217 32-8530	
17. INFORMANT Mrs. Augusta Meinl, Balto. 28, Md.		ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Sub-arachnoid hemorrhage		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		(A) Sub-arachnoid hemorrhage DUE TO (B) Intra-ventricular hemorrhage DUE TO (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from AUGUST 9 19 65 to AUGUST 9 19 65 , that (I) (we) lost saw the deceased alive on AUGUST 9 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Esther Seiden		23B. DATE SIGNED Aug. 10 / 65	
23C. PHYSICIAN'S NAME (Type) M.D.		23D. ADDRESS M.D. ST. AGNES HOSPITAL, WILKENS & CATON AVE.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/13/65	
24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore 29, Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1965		25B. NAME OF REGISTRAR Robert E. Fagundes	
25C. FUNERAL DIRECTOR Witzke F.D. 4101 Edmondson Ave		ADDRESS	



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)KATHERINE Or Quintilian
QUINTILIN

2. DATE AND HOUR PRONOUNCED DEAD

8-8-65

4 PM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4509 Kenwood Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

December 5 1918

9. AGE (in years
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Taylor Shop

10B. KIND OF BUSINESS OR INDUSTRY

Tie Maker

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Anthony Onorato

14. MOTHER'S MAIDEN NAME

Anna Brocato

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-03-7053

17. INFORMANT

ADDRESS

Roseanna Ruppertsberger 2420 Windsor Rd #34

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Aspiration pneumonia following
DUE TO cholecystectomy

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

8-9-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Aug 11 1965

23C. NAME of CEMETERY or CREMATORY

Gardens of Faith Cemetery

23D. LOCATION (City, town, or county)

Trumps Mill Road

Md

24A. DATE REC'D BY HEALTH DEPT.

AUG 11 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Dippel Brothers Inc 7110 Belair Road

ADDRESS

December 2, 1970

• • • • •

51. *Chrysomelidae*

• **rest off**

cc2 105

1970-1971 1972-1973

Anthony Daniels

- 2 -

2

Printed by the Government Printer, Ottawa, Ontario, Canada.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

65 8311		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8311	
BIRTH NO.		<div style="font-size: 2em; font-weight: bold;">X</div> <div style="font-size: 1.5em; font-weight: bold;">CERTIFICATE OF DEATH</div>		2. DATE AND HOUR OF DEATH	
M.E. CASE NO.				August 8, 1965 2:45 A.M.	
1. NAME OF DECEASED (Type or Print) Helen Theresa Martin				3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
Villa Marie Nursing Home		6400 Bellona Avenue		A. STATE Maryland	
				B. COUNTY Baltimore	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
				D. STREET ADDRESS (If rural, give location) 6810 Pinehurst Road	
5. SEX Female	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Jan. 19, 1882	9. AGE (In years last birthday) 83 yrs.	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles M. Loane		14. MOTHER'S MAIDEN NAME Theresa Baurer	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Gertrude Wagner 6810 Pinehurst Rd.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Acute myocardial infarction DUE TO (B) Coronary Arteriosclerosis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 10 hours	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/7 19 65 to 8/8 19 65, that (I) (we) last saw the deceased alive on 8/7 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. Richard Fravel				23B. DATE SIGNED Aug. 10, 1965	
23C. PHYSICIAN'S NAME (Type) C. Richard Fravel				23D. ADDRESS 706 Medical Arts Building Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 11 65		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR The Dippel Brothers Inc. 7110 Belair Rd. 6	

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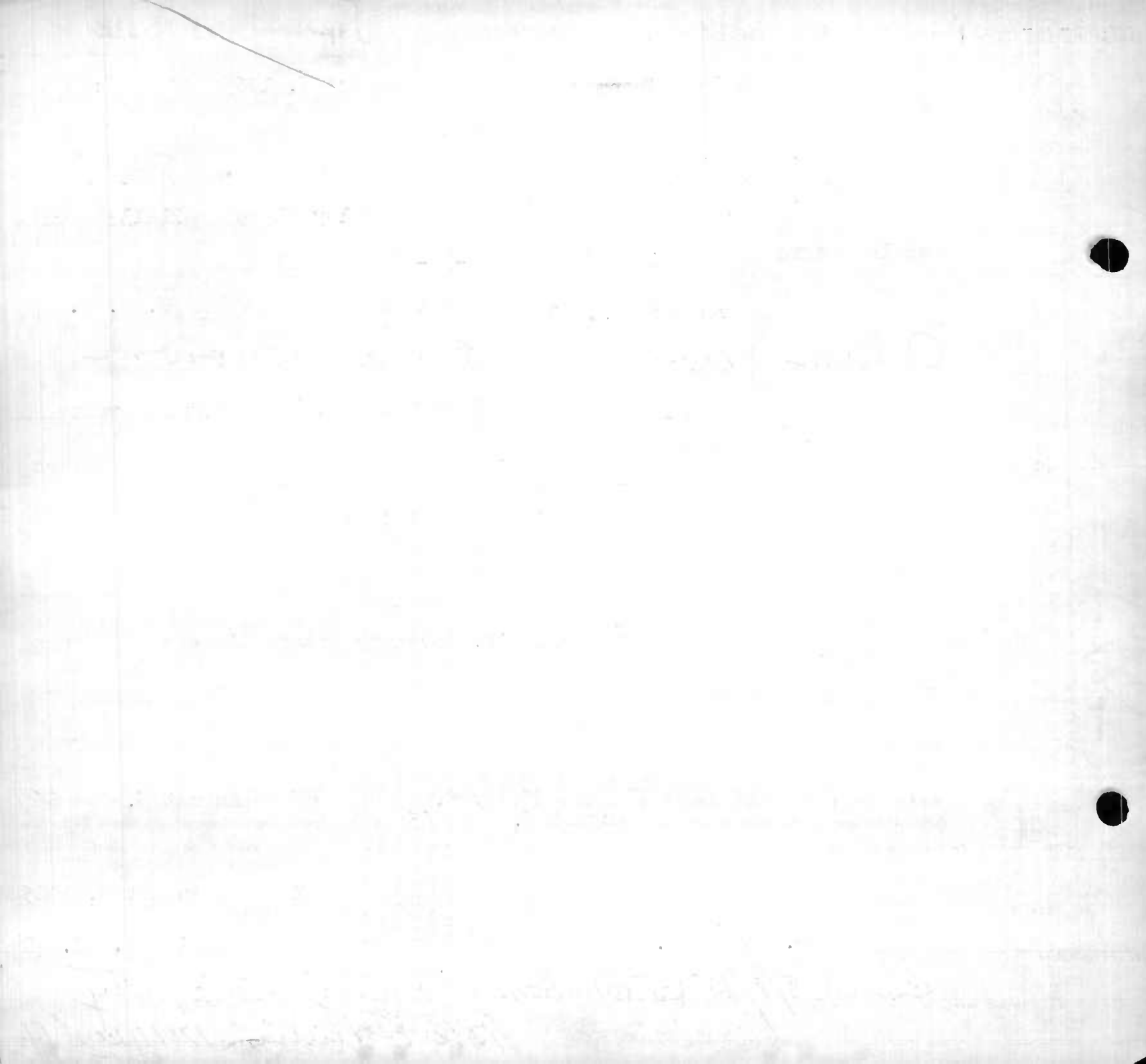
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LS: 43-52-78

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

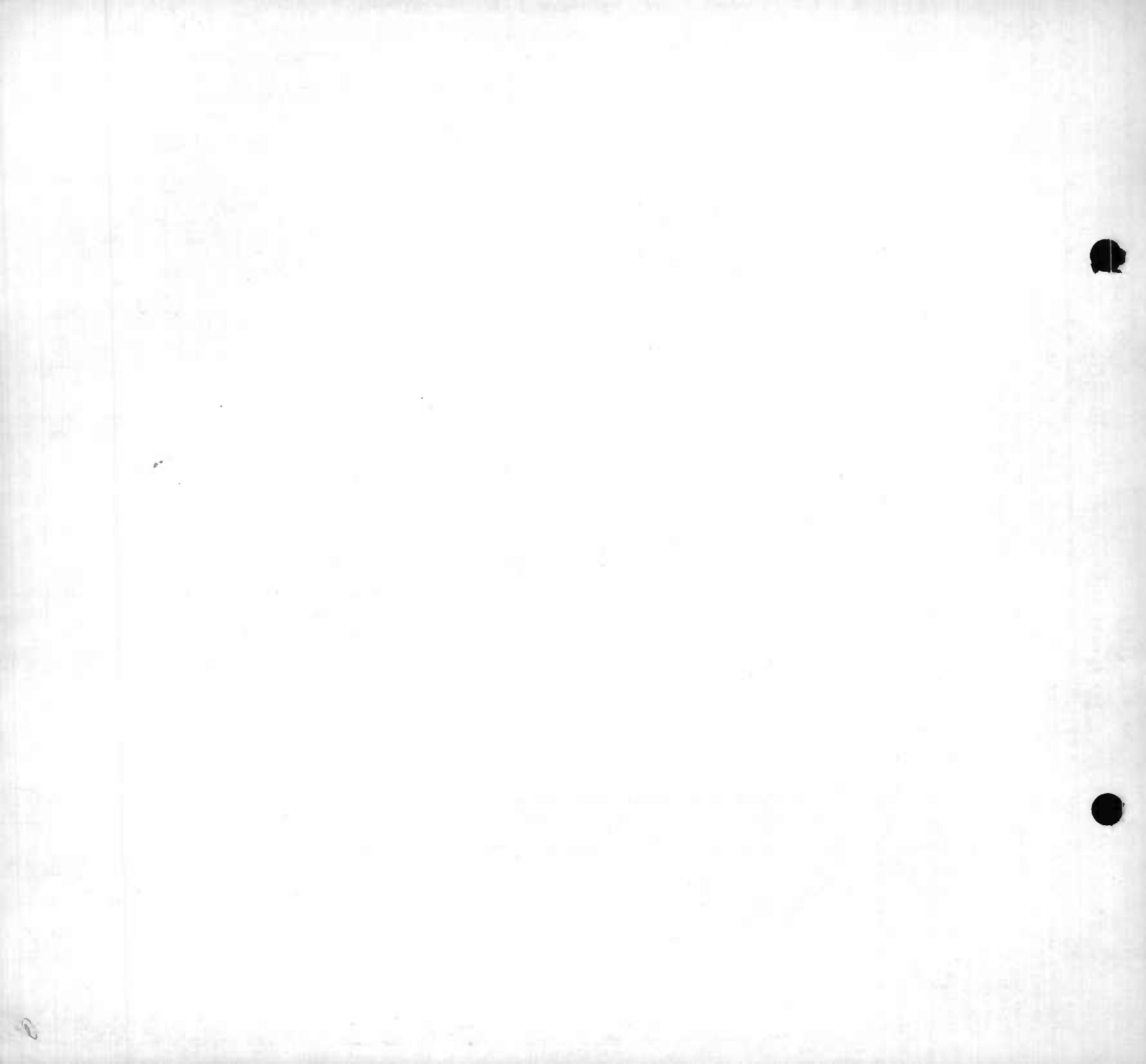
BIRTH NO. 65 8312		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8312	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		Annie Chapman		2. DATE AND HOUR OF DEATH August 5, 1965 5:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		Maryland		A. STATE	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
D. STREET ADDRESS (If rural, give location)		1607 Haskins Place		#21213 HA KESLEY	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 8-30-97	9. AGE (In years last birthday) 67	10. UNDER 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY House Wife		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Adam Jews		14. MOTHER'S MAIDEN NAME Eliza Brown		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: BCH: 4940 Eastern Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 260X1X008.1		CAUSE OF DEATH (A) Uremia DUE TO		INTERVAL BETWEEN ONSET AND DEATH Years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Diabetes Mellitus DUE TO		Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Tuberculosis, Coronary Artery Disease		Years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 6, 19 65 to August 5, 19 65, that (I) (we) last saw the deceased alive on August 5, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. Rath		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 5, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS Dr. Howard K. Rathbun M.D. 4940 Eastern Avenue Baltimore, Md. #24			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8/8/65		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery Baltimore, City	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1965		25B. NAME OF REGISTRAR Robert E. Williams		25C. FUNERAL DIRECTOR 1701 N. Bond St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO.		65 8313		CERTIFICATE OF DEATH		Registered No. 65 8313			
1. NAME OF DECEASED (Type or Print) COLEMAN, LEO ANDREW					2. DATE AND HOUR OF DEATH 8-9-65 1515 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 9-08 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 636 ST. ANNS AVE.				
5. SEX MALE		6. RACE NEGRO		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SEP.		8. DATE OF BIRTH 12-28-09		9. AGE (In years lost birthday) 55	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter			10B. KIND OF BUSINESS OR INDUSTRY —			11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALBERT COLEMAN					14. MOTHER'S MAIDEN NAME MAGGIE THOMPSON				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN					16. SOCIAL SECURITY NO. —		17. INFORMANT CHART & HOSPITAL		
18. 525X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ACUTE PULMONARY EDema					CAUSE OF DEATH (A) ACUTE PULMONARY EDema DUE TO (B) — DUE TO (C) EMPHYSEMA		INTERVAL BETWEEN ONSET AND DEATH 1 WEEK		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II					OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. EMPHYSEMA POST OP @ PNEUMONECTOMY				
19A. DATE OF OPERATION 05-6-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CHRONIC Inflammation (Lung)			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8-2-65 to 8-9-65 , that (I) (we) last saw the deceased alive on 8-9-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Thomas B. Grollman M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 8-9-65	
23C. PHYSICIAN'S NAME (Type) THOMAS B. GROLLMAN M.D.					23D. ADDRESS UNIVERSITY HOSP, BALT., MD.				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-12-65		24C. NAME OF CEMETERY or CREMATORY MT. CALVARY Cem.			24D. LOCATION (City, town, or county) (State) ANN ARUNDEL CO. MD.		
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1965			25B. NAME OF REGISTRAR R. E. Taylor MD			25C. FUNERAL DIRECTOR Joseph M. Locke Jr. ADDRESS 13047 Central Ave			



BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 831 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 8314

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EUGENE HARRISON

2. DATE AND HOUR PRONOUNCED DEAD

8/8/65 1:49 a.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1537 Broadway

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

7-23-45

9. AGE (In years
last birthday)

21

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

TILE MAKER

10B. KIND OF BUSINESS OR INDUSTRY

WEBTEX CO.

11. BIRTHPLACE (State or foreign country)

NORFOLK VA.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JAMES REESE

14. MOTHER'S MAIDEN NAME

LOUISE HARRISON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

212-42-8742

17. INFORMANT

LOUISE

ADDRESS

GILMORE 204 HERRING

18.

E982X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Stab wound of abdomen, involving aorta
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

in front of 1700 N. Caroline St.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8 8 65 1:30a

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

stabbed during altercation

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/8/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

8-12-65

23C. NAME of CEMETERY or CREMATORY

MT. CALVARY CEM.

23D. LOCATION

(City, town, or county)

(State)

ANN ARUNDEL CO. MD.

24A. DATE REC'D BY HEALTH DEPT.

AUG 11 1965

24B. NAME OF REGISTRAR

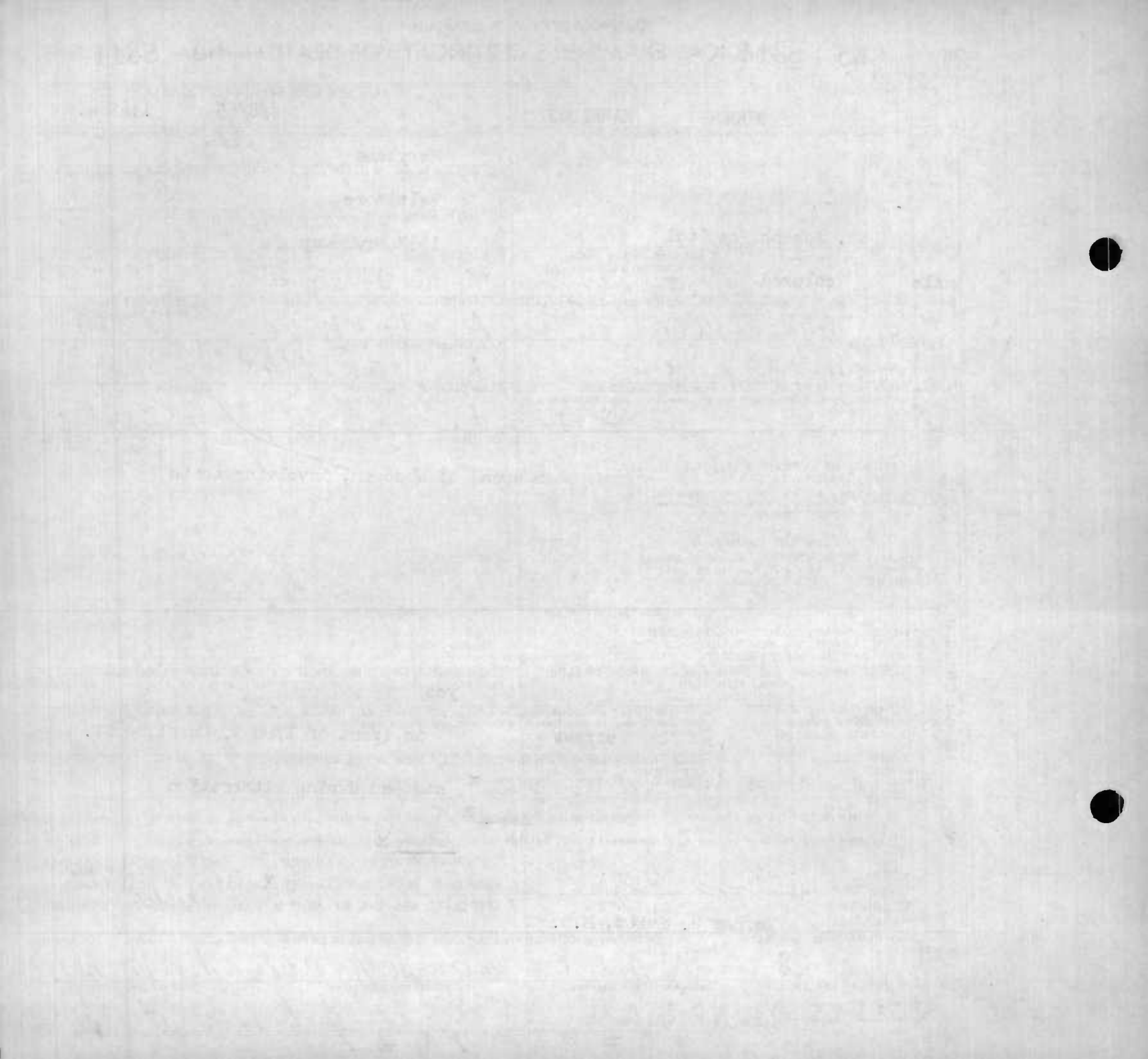
Robert E. Fairbank

24C. FUNERAL DIRECTOR

Joseph H. Locke Jr.

ADDRESS

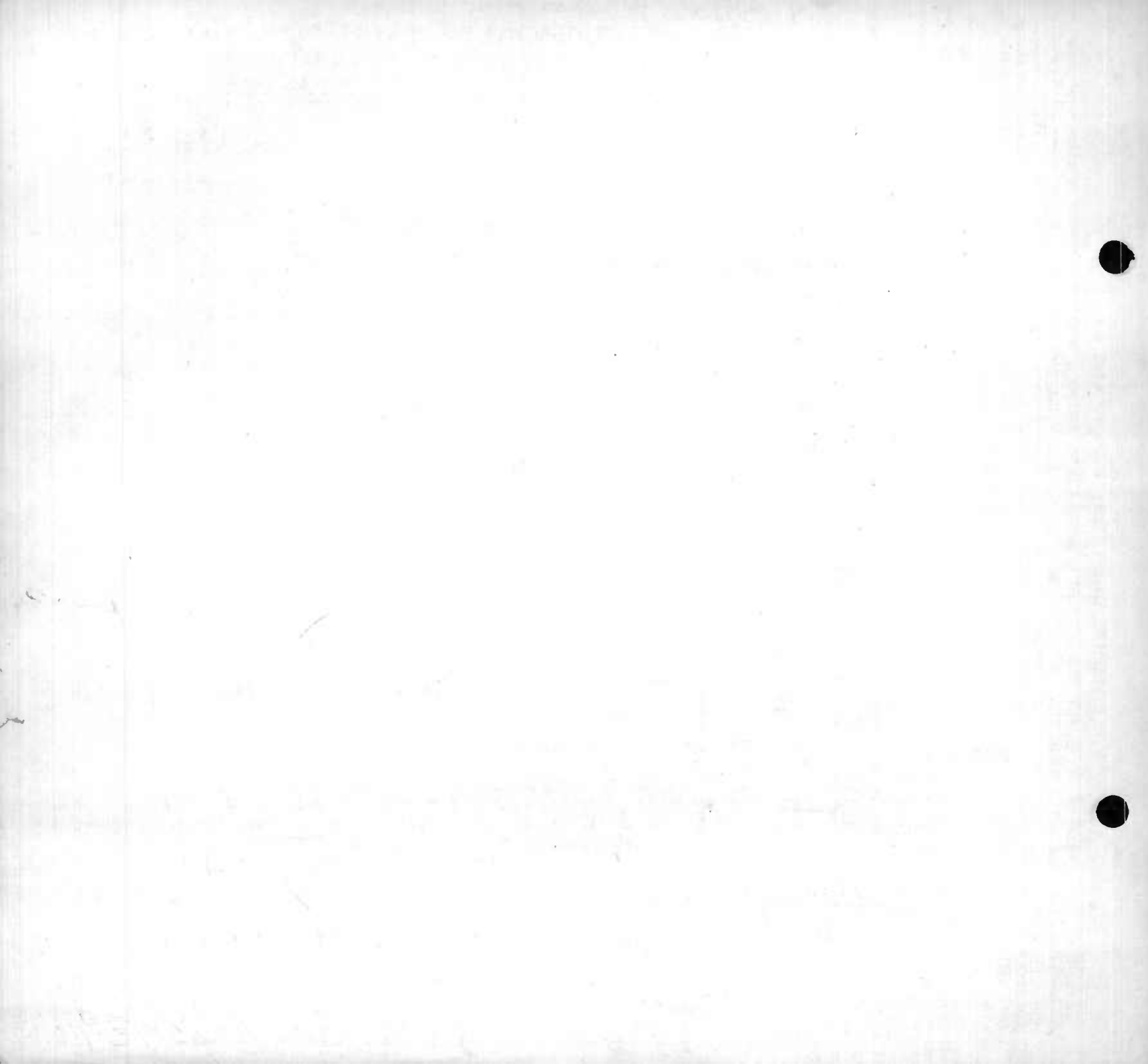
1304 N. Kentland Ave



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

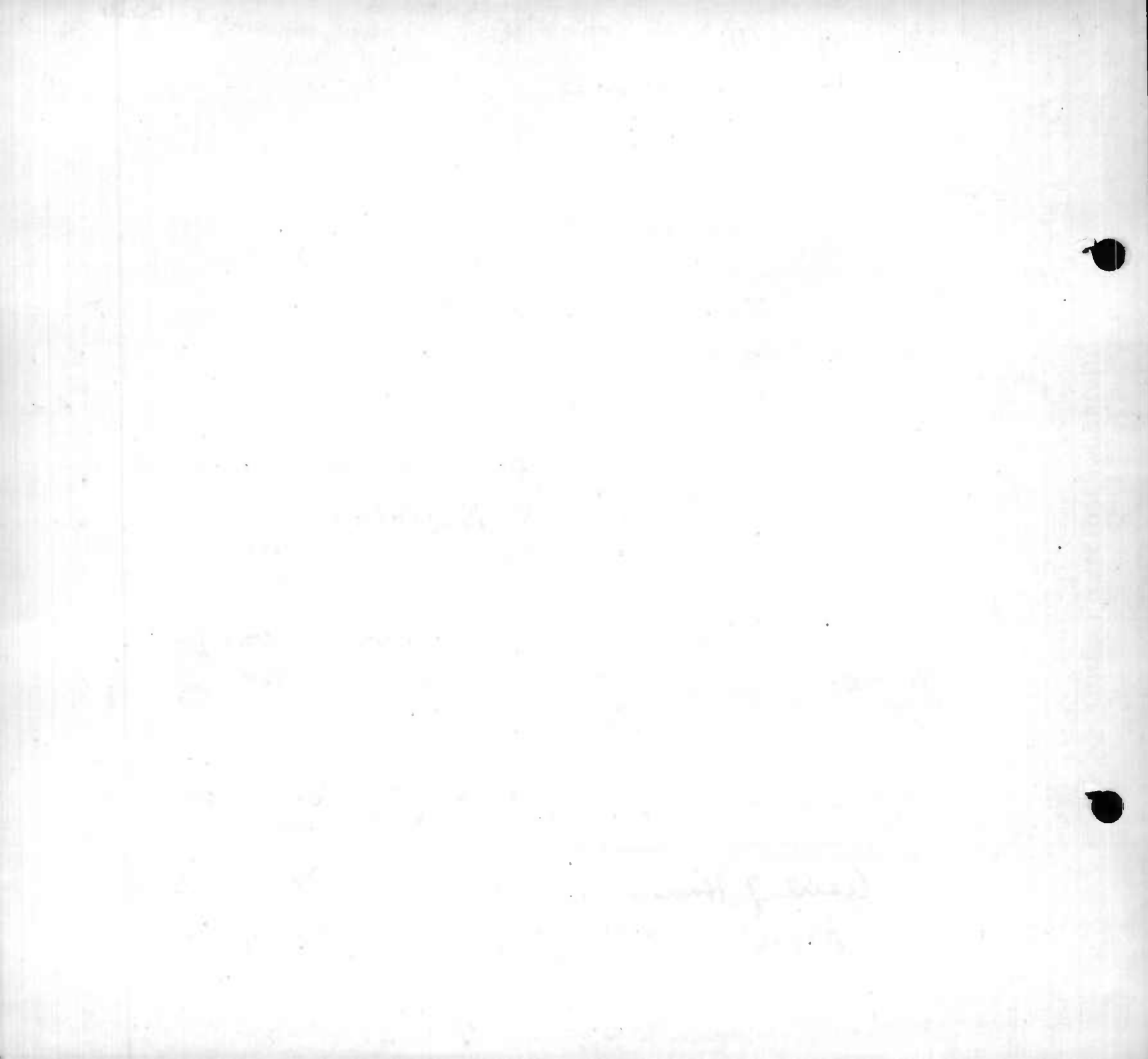
BIRTH NO. 65 8315				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8315	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CLAUDE RICHARDSON				2. DATE AND HOUR OF DEATH 8-8-65 19 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 10-02	
The Johns Hopkins Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 818 North Central Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 8/25/18	9. AGE (In years lost birthday) 47	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME James Richardson			14. MOTHER'S M maiden name Rose				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Helen Richardson		ADDRESS 1903 Perlman Pl
18. 581.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) HEPATIC COMA			CAUSE OF DEATH (A) DUE TO HEPATIC COMA			INTERVAL BETWEEN ONSET AND DEATH 1 DAY	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO LAENNEC'S CIRRHOSIS			6 YRS	
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8-7-65 to 8-8-65 19 65 that (I) (we) last saw the deceased alive on 8-8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ashley T. Haase				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-8-65	
23C. PHYSICIAN'S NAME (Type) ASHLEY T. HAASE				23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-12-65		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Em Balto		24D. LOCATION (City, town, or county) (State) Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1965		25B. NAME OF REGISTRAR Robert E. Finken		25C. FUNERAL DIRECTOR Raymond Sanders		ADDRESS 317 E Preston	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

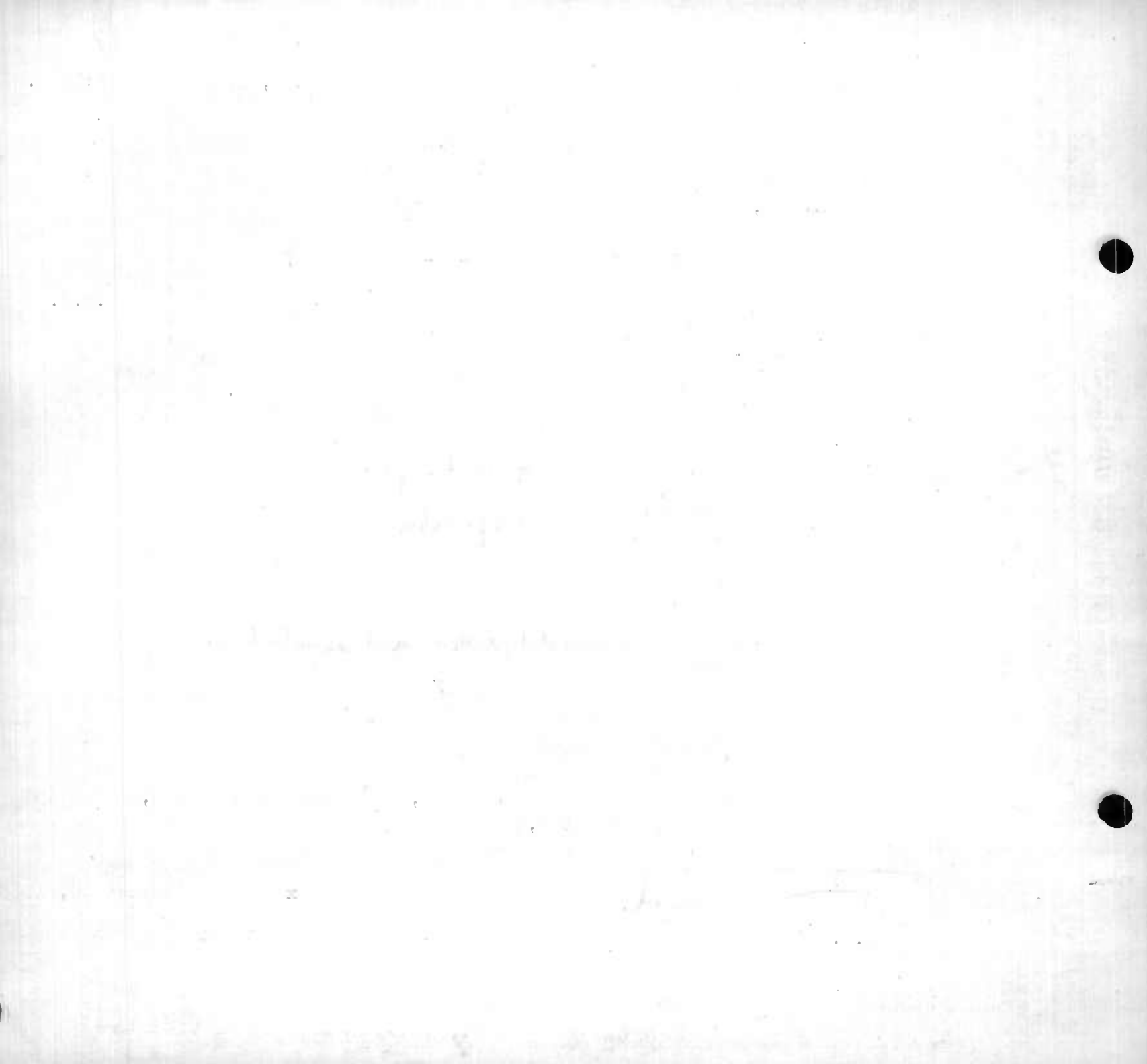
BIRTH NO. 65 8316				BALTIMORE CITY HEALTH DEPARTMENT		65 8316	
M.E. CASE NO. 65 8316				CERTIFICATE OF DEATH		Registered No. 65 8316	
1. NAME OF DECEASED (Type or Print) EARLIE BLACKWELL				2. DATE AND HOUR OF DEATH 8-10-65 9:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-09			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 1624 Harford Road			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/24/95	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Danville Va		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frank R. Blackwell			14. MOTHER'S MAIDEN NAME Katie Hicks				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 212-83-1634		17. INFORMANT Carnie Blackwell		ADDRESS Same
18. 199.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRAIN STEM VASC. ACCIDENT 10 DAYS				(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO MYOPATHY ? CA. 3 YRS.			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CHRONIC URINARY TR. INFECTION							
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) —		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —			
22. I certify that (I) (this hospital) attended the deceased from 8-5-65 to 8-10-65 , that (I) (we) last saw the deceased alive on 8-10-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ashley T. Harse				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-10-65	
23C. PHYSICIAN'S NAME (Type) ASHLEY T. HARSE				23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/1965		24C. NAME OF CEMETERY or CREMATORY Putnam Cemetery		24D. LOCATION (City, town, or county) (State) Brooklyn Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Gleason Wilson		ADDRESS 1000 Brantley Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH											
BIRTH NO.		Registered No.									
M.E. CASE NO.		65 8317									
1. NAME OF DECEASED (Type or Print)						2. DATE AND HOUR OF DEATH					
Annie Townsend						August 9, 1965 1:15 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)						A. STATE B. COUNTY					
Provident Hospital 1514 Division Street Baltimore, Maryland						Maryland Howard					
C. CITY OR TOWN (If outside city limits, write RURAL and give township)						Jessup					
D. STREET ADDRESS (If rural, give location)						Box 436					
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Yr. Months Days Hours Min.	
Female		Negro		Widowed		8-27-1878		87			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
						Maryland			U.S.A.		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
						Mary Thomas					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		
No.						Marie Anne Young			3443 Jessup Rd		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH						CAUSE OF DEATH					
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)						(A) Broncho pneumonia					
ANTECEDENT CAUSES						(B) aspiration					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(C)					
II						OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
						Severe dehydration and demutiation.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
2				yes							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from July 30, 1965 to August 9, 1965, that (I) (we) last saw the deceased alive on August 9, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE								M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
A.R. Rigaud										August 10, 1965	
23C. PHYSICIAN'S NAME (Type)				M.D.		23D. ADDRESS					
A.R. Rigaud						1514 Division Street					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
8-12-1965 Burial				Jessup Cent				Jessup			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR				ADDRESS			
AUG 11 1965		Robert E. Talbot		Chas. A. Wilson				1001 Brantly Ave			



1

65 8318

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 8318

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PERCY CARMACK

2. DATE AND HOUR PRONOUNCED DEAD

8-9-65

8:35 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

CHURCH HOME AND HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

523 S. Caroline Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Jan 25 1906

9. AGE (In years last birthday)

57

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

212-12-9351

17. INFORMANT

Hilda Dolles

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Bronchogenic carcinoma
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

P. W. Rieckert

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

8-9-65

EXAMINER'S NAME (Type)

PETER W. RIECKERT, M.D.

23A. BURIAL CREMATION, REMOVAL (Specify)

Buried

23B. DATE

8-13-1965

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cent

23D. LOCATION (City, town, or county) (State)

Brooklyn Md

24A. DATE REC'D BY HEALTH DEPT.

AUG 11 1965

24B. NAME OF REGISTRAR

Robert E. Farkas, M.D.

24C. FUNERAL DIRECTOR

Eloy G. Wilson - 1000 Brantley Ave

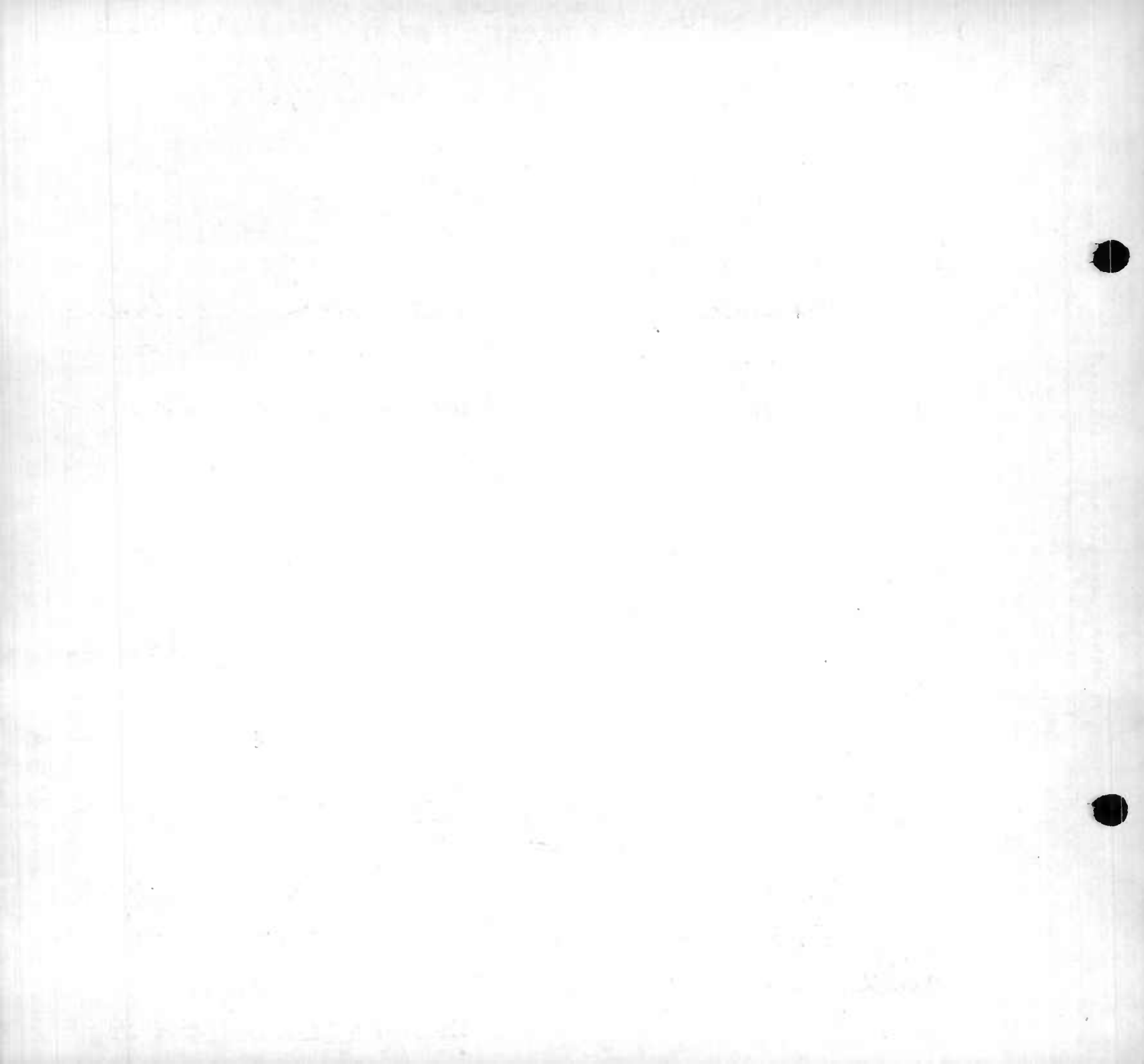
ADDRESS

WALLER & POLICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8319	
BIRTH NO. 65 8319		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED Ruth Banks		2. DATE AND HOUR OF DEATH 8/11/65 4:30 A.M.	
1. NAME OF DECEASED (Type or Print)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 13	
				D. STREET ADDRESS (If rural, give location) 1813 Patterson Park Ave.	
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1-8-23	9. AGE (In years last birthday) 42	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Clarence Charles			14. MOTHER'S MAIDEN NAME Rose Carter		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT William Banks		ADDRESS Same
18. 436X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Systemic lupus erythematosus (B) (C) INTERVAL BETWEEN ONSET AND DEATH 3 wks.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 8/5 19 65 to 8/11 19 65 , that (we) last saw the deceased alive on 8/11 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE E. Eugene Page Jr.				23B. DATE SIGNED 8/11/65	
23C. PHYSICIAN'S NAME (Type) E. Eugene Page Jr.				23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-14		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cent	
24D. LOCATION (City, town, or county) (State) Brooklyn Md		25A. DATE REC'D BY HEALTH DEPT. AUG 11 1965		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR Elroy G. Wilson		25D. ADDRESS 1000 Brantly Ave			



BIRTH NO. 65 8320 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) BEATRICE CHAPMAN				2. DATE AND HOUR PRONOUNCED DEAD 8-11-65 12:25 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD UNIVERSITY HOSPITAL - DOA				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY X C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2328 Nevada Street			
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Apr. 3, 1913	9. AGE (In years last birthday) 52	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME More Chapman				14. MOTHER'S MARDEN NAME Lucy Collins			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Clara Moore		ADDRESS Same	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB- UTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
21D TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) RUDIGER BREITENECKER, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-11-65							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 8-14-1965		23C. NAME of CEMETERY or CREMATORY Chocowinity Cent		23D. LOCATION (City, town, or county) (State) Washington D.C.	
24A. DATE REC'D BY HEALTH DEPT. AUG 11 1965		24B. NAME OF REGISTRAR Robert E. Faldut		24C. FUNERAL DIRECTOR Bartholomew J. Horner		ADDRESS	

VALLEY POLICE

VALLEY POLICE

VALLEY POLICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8321		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8321	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Charlotte Corden		2. DATE AND HOUR OF DEATH 8-8-1965 12:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 3300 D. STREET ADDRESS (If rural, give location) 4109 Old North Point Road 21222			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 11-13-1887	9. AGE (In years last birthday) 74 177	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy	12. CITIZEN OF WHAT COUNTRY? Italy
13. FATHER'S NAME George Zolla			14. MOTHER'S MAIDEN NAME Libra Zolla		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224	
18. 43441 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Pneumonia DUE TO Pulmonary Edema (B) Digitalis Toxicity (C)		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days 5 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-1-1965 to 8-8-1965, that (I) (we) last saw the deceased alive on 8-8-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. Rathbun		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-8-1965	
23C. PHYSICIAN'S NAME (Type) Dr. H. Rathbun		23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-12-65		24C. NAME OF CEMETERY or CREMATORY Mount Carmel Cemetery	
24D. LOCATION (City, town, or county) (State) Somerset County, Pennsylvania		25A. DATE REC'D BY HEALTH DEPT. AUG 11 1965			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard-4107 Wilkens Avenue-21229			

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 8322

1. NAME OF DECEASED
(Type or Print)

AUGUSTA V. JORDAN

2. DATE AND HOUR PRONOUNCED DEAD

8/7/65 5:10 p.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1307 S. Carey St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1307 S. Carey St.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

12-23-85

9. AGE (In years
last birthday)

79

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Standard Oil Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John L. Herbert

14. MOTHER'S MAIDEN NAME

Theresa J.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Catherine Daly-1918 Griffiss Ave-21230

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
(If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner H. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/8/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-11-65

23C. NAME OF CEMETERY or CREMATORY

Moreland Memorial Park

23D. LOCATION

Balto. County

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 11 1965

24B. NAME OF REGISTRAR

Robert E. Fickens

24C. FUNERAL DIRECTOR

Howard H. Hubbard-4107 Wilkens Avenue-21229

ADDRESS

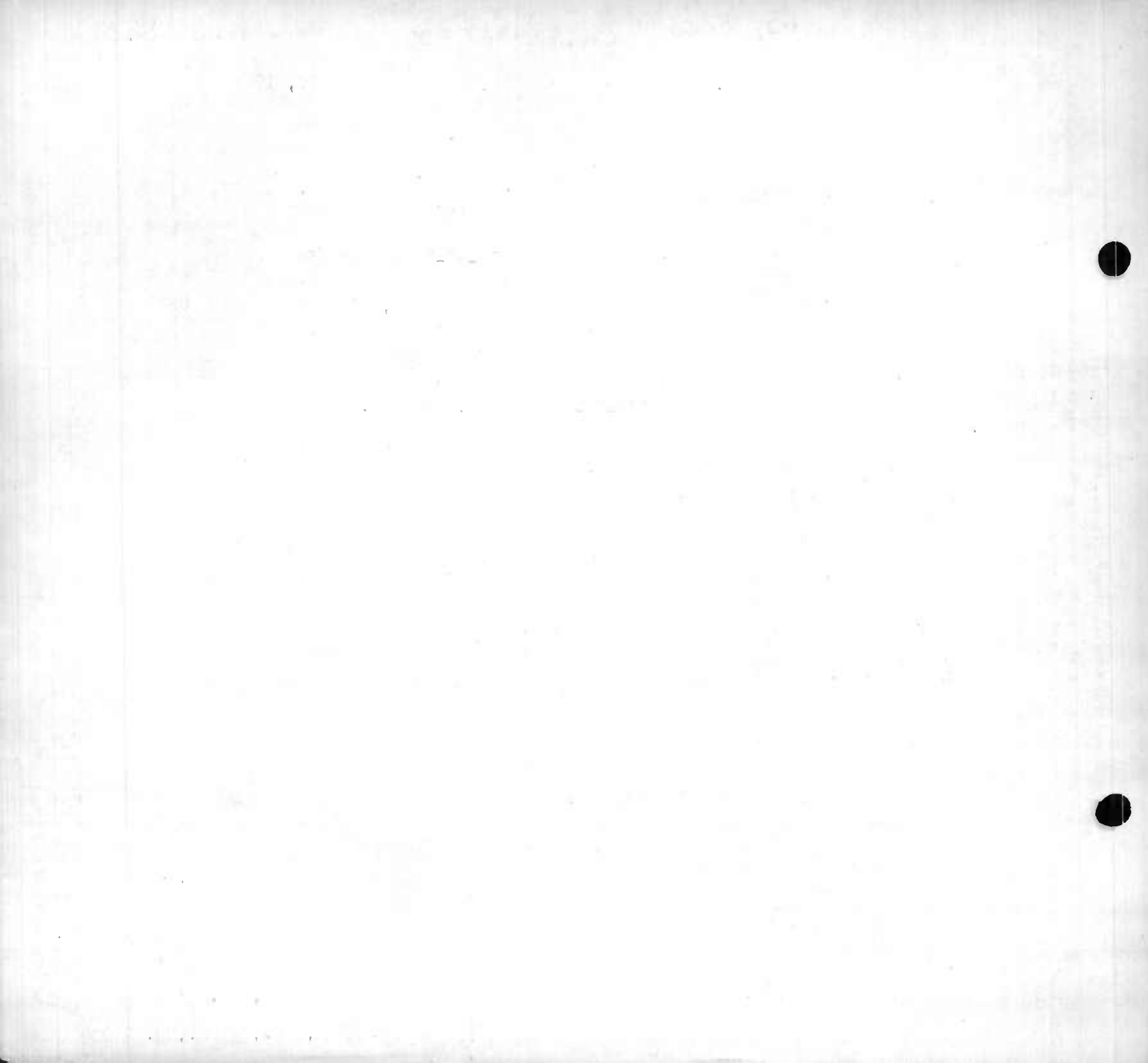
VALLEY VIEW COLLEGE

[Handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8323		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8323	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ANTHONY W. HODEK			2. DATE AND HOUR OF DEATH AUGUST 10, 1965 12:30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3436 KENYON AVENUE			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 26-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. D. STREET ADDRESS (If rural, give location) 3436 KENYON AVENUE		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11-23-1899	9. AGE (In years lost birthday) 65	10. Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PAINTER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME WENCESLAUS HODEK			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 216-10-8842		17. INFORMANT MRS. HELEN A. HODEK
			ADDRESS SAME		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) DUE TO Coronary of Raryn (B) DUE TO (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH 3 years.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION April 1962		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Obstruction of Gall Cords		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 19 61 to August 10 19 65, that (I) (we) last saw the deceased alive on August 9 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE MELVIN F. POLEK, M.D.				23B. DATE SIGNED 8/10/65	
23C. PHYSICIAN'S NAME (Type) MELVIN F. POLEK		23D. ADDRESS M.D. 3603 Belair Road, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/13/65		24C. NAME OF CEMETERY or CREMATORY HOLY ROSARY CEMETERY	
				24D. LOCATION BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1965		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC., BALTO., MD. 21214	



1
F-656

65 8324

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 8324

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FRANCIS K. FARMER, JR.

2. DATE AND HOUR PRONOUNCED DEAD

8/10/65 7:35 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

4127 Marx Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4127 Marx Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED

8. DATE OF BIRTH

JUNE 13, 1908

9. AGE (In years
last birthday) 57If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

FOREMAN

10B. KIND OF BUSINESS OR INDUSTRY

PAINT CONTRACTOR

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

FRANCIS K. FARMER, SR.

14. MOTHER'S MAIDEN NAME

ADELE FAHEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

216-05-8442

17. INFORMANT

MRS. BARBARA C. FARMER

ADDRESS

SAME

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN DETERMINING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/10/65

23A. BURIAL CREMATION,
REMOVAL (Specify)
BURIAL

23B. DATE

8/13/65

23C. NAME OF CEMETERY or CREMATORY

PARKWOOD CEMETERY

23D. LOCATION

(City, town, or county)

BALTIMORE, MD.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 11 1965

LEONARD J. RUCK, INC., BALTO., MD. 21214

WALLER POLICE

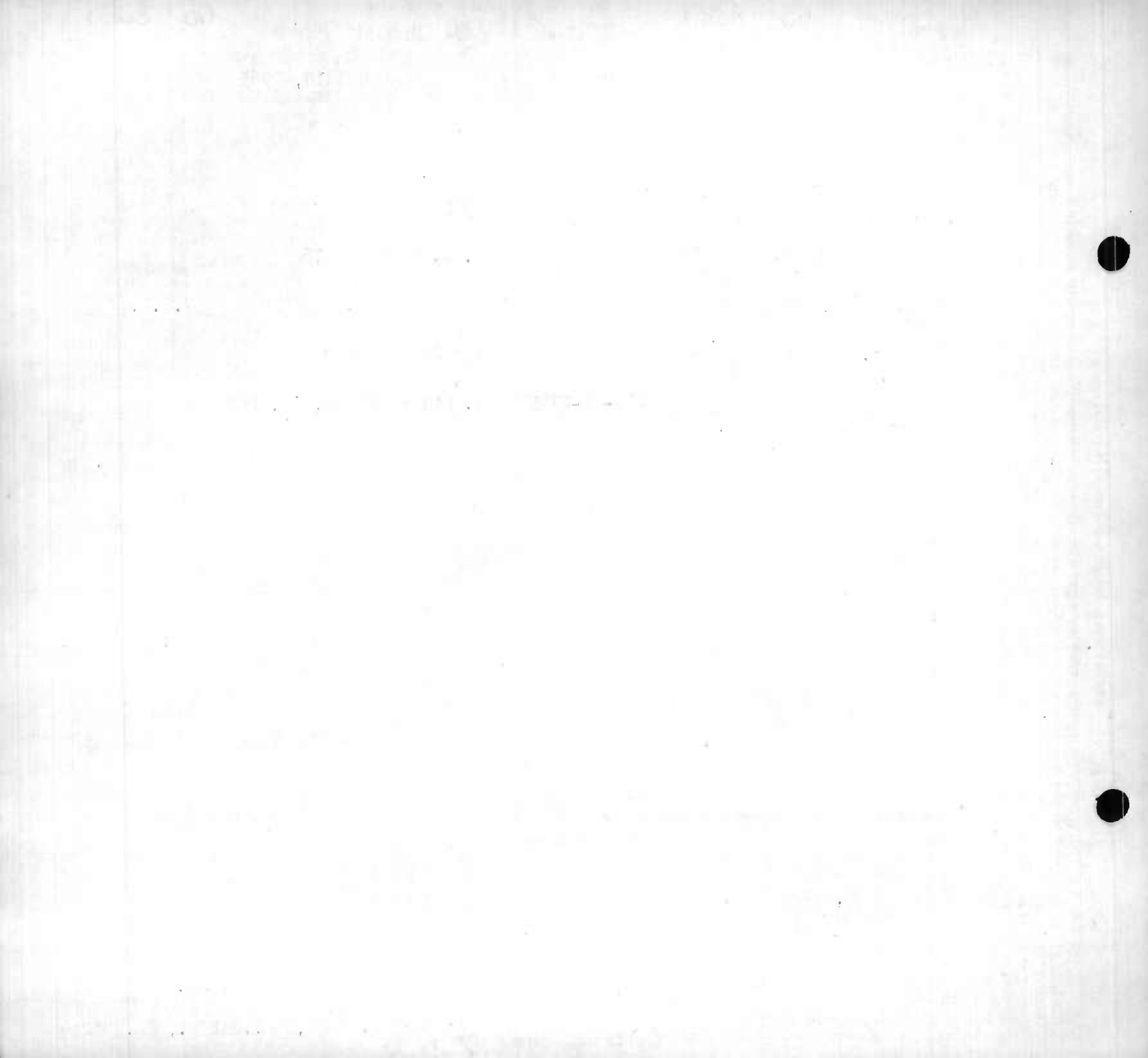
11

11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8325	
BIRTH NO. 65 8325		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) EMORY O. TAYLOR		2. DATE AND HOUR OF DEATH AUGUST 10, 1965 10:15 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) HARFORD GARDENS NURSING HOME		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 26-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. D. STREET ADDRESS (If rural, give location) 4312 SHAMROCK AVENUE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH OCT. 2, 1888	9. AGE (In years lost birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CARPENTER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CARROLL COUNTY, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JESSE M. TAYLOR		14. MOTHER'S MAIDEN NAME MARY JANE SLOPP	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-03-2785		17. INFORMANT ADDRESS MR. HARRY MILLER, JR. 2617 MATTHEWS DRIVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.1 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 2 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 1965 to August 1965, that (I) (we) last saw the deceased alive on August 9, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Loy M. Zimmerman</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/10/65	
23C. PHYSICIAN'S NAME (Type) Loy M. Zimmerman		23D. ADDRESS M.O. 3202 Harford Rd, Baltimore Md			
24A. BURIAL CREMATION REMOVAL (Specify) BURIAL		24B. DATE 8/13/65		24C. NAME OF CEMETERY OR CREMATORY SANDY MOUNT CEMETERY	
24D. LOCATION (City, town, or county) WESTMINSTER, MD.		25A. DATE REC'D BY HEALTH DEPT. AUG 11 1965			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS LEONARD J. RUCK, INC., BALTO., MD. 21214			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8326		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 8326	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) SIRGANY, THOMAS			2. DATE AND HOUR OF DEATH 8-7-65 8:22 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Balt		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 6		
			D. STREET ADDRESS (If rural, give location) 6 Madeline Ave		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 3-21-09	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PA R.R. employee		10B. KIND OF BUSINESS OR INDUSTRY Conductor		11. BIRTHPLACE (State or foreign country) Pa	
13. FATHER'S NAME Aileen Sirgany			14. MOTHER'S MAIDEN NAME Mary Maroon		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Navy WW II			16. SOCIAL SECURITY NO. 207-05-7026		17. INFORMANT chart
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO Myocardial Infarction Acute, Apophrenic & lateral extension (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-7-65
23C. PHYSICIAN'S NAME (Type) Wm Cook Brooks			23D. ADDRESS Church Home & Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE Aug. 8, 1965		24C. NAME of CEMETERY or CREMATORY Sacred Heart Cemetery	
				24D. LOCATION (City, town, or county) (State) Scranton Penna.	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1965		25B. NAME OF REGISTRAR Wm Cook Brooks		25C. FUNERAL DIRECTOR ADDRESS Wm Cook Brooks, Inc. 1217 St. Paul St.	

Set 1000 1/2 1000 2

1000 1/2

1000 1/2

Green more - right

Green more - right

3-1-01 25

M. W.

Green more - right

Green more - right

Chart

Chart

Physiological Laboratory
University of California
Berkeley

W. B. Keen

Green more - right

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8327				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8327	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Miss Catherine U Parsons				2. DATE AND HOUR OF DEATH 8:49am 8/9/65			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital Baltimore, Maryland				A. STATE B. COUNTY Maryland 27-01			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 4130 Marx Ave			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 1/4/83	9. AGE (In years lost birthday) 82	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Webster Parsons				14. MOTHER'S MAIDEN NAME Catherine Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS Mrs. Theodora Sladky 4130 Marx Ave.	
18. 570.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Intestinal Obstruction Fecal Impaction (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/6 19 65 to 8/9 19 65, that (I) (we) lost saw the deceased alive on 8/9 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. Stephen Margolis				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/9/65	
23C. PHYSICIAN'S NAME (Type) J. Stephen Margolis				23D. ADDRESS Maryland General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/11/65		24C. NAME of CEMETERY or CREMATORY Mt. Olivet Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1965		25B. NAME OF REGISTRAR Robert E. Bailey		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc.		ADDRESS 1217 St. Paul St. 21202	

11/11/83

General Hospital

General Hospital
11/11/83

11/11/83

General Hospital

General Hospital

11/11/83

General Hospital

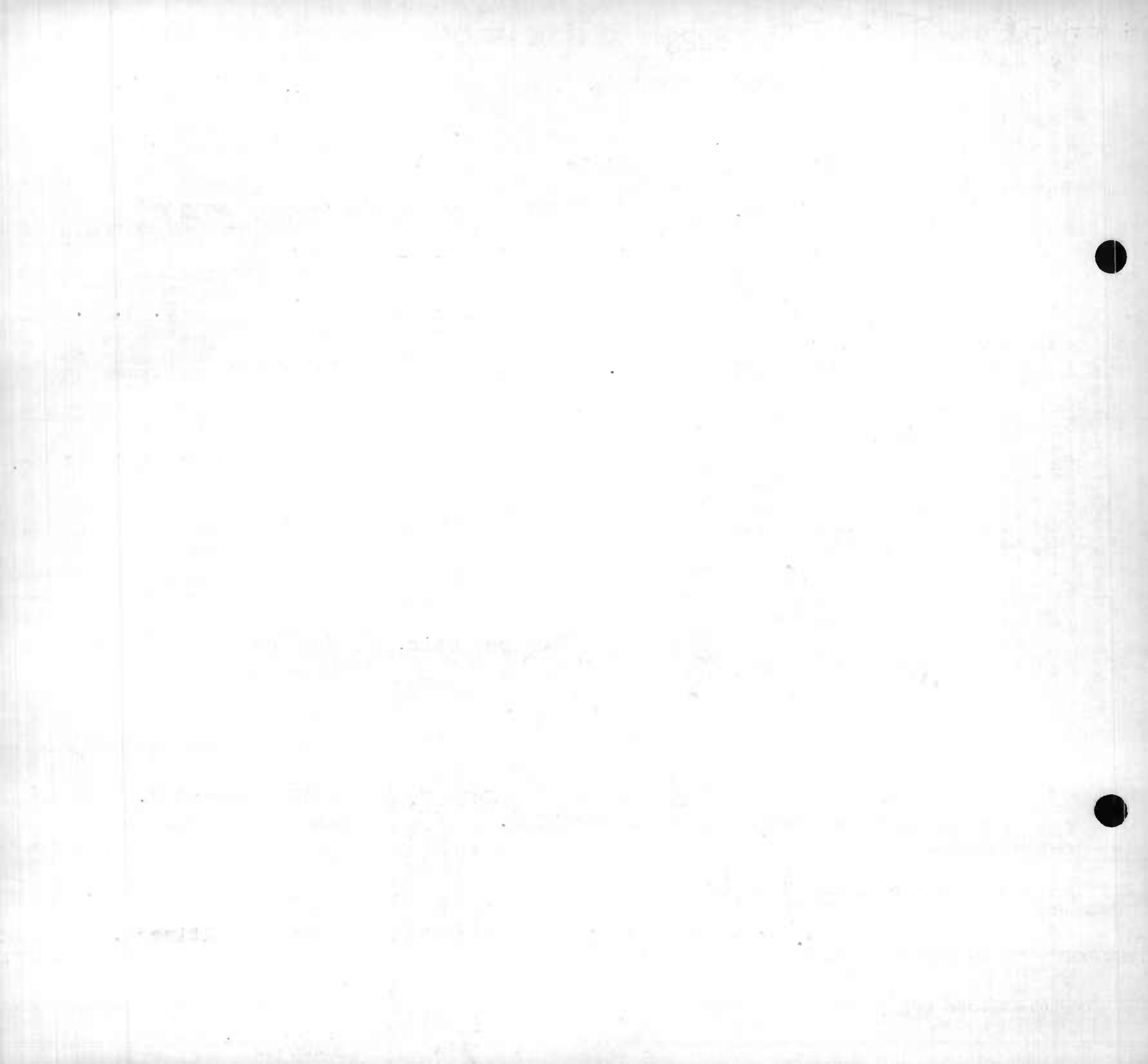
General Hospital

S: 44-08-761

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

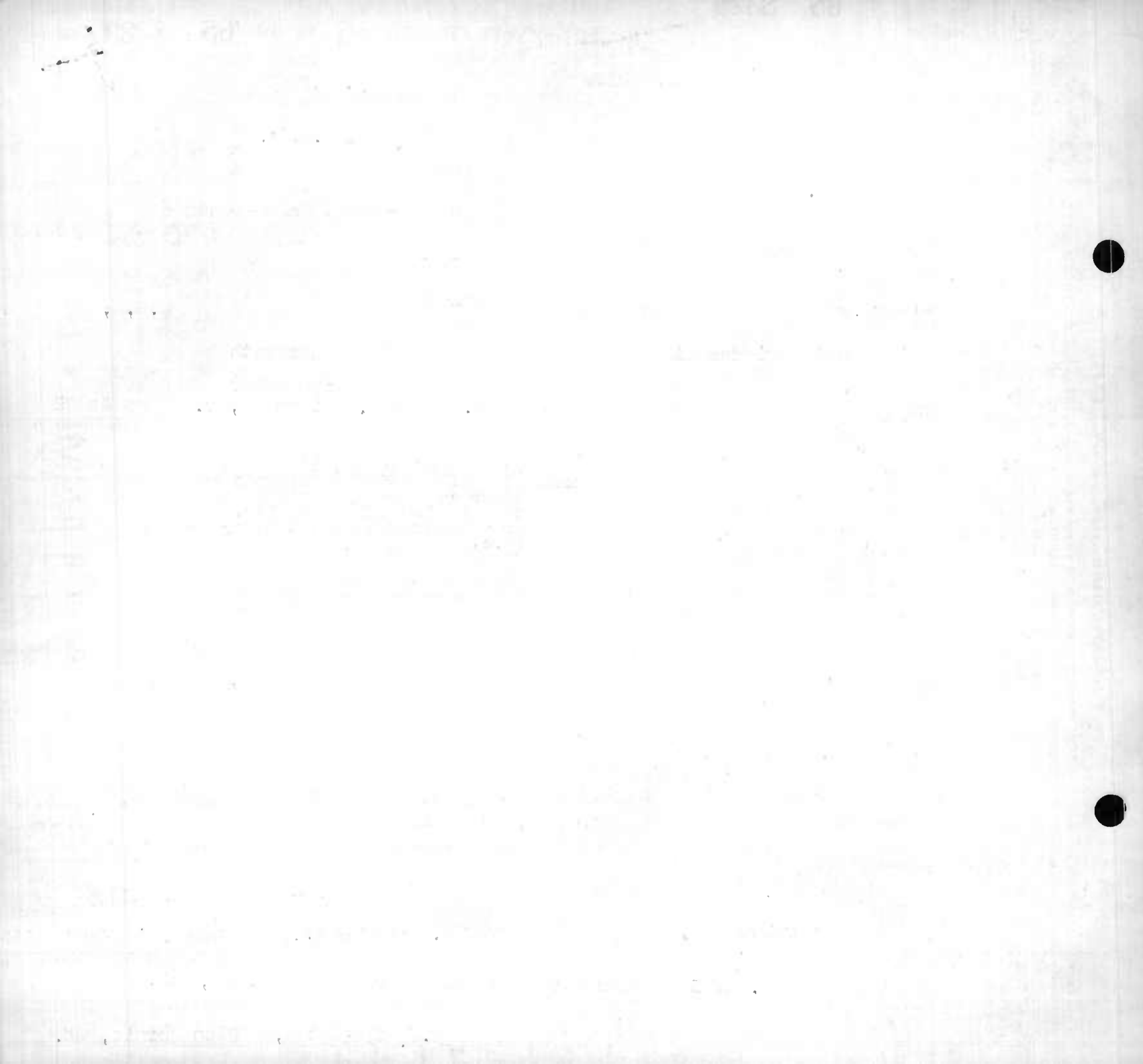
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8328	
BIRTH NO. 65 8328		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
		Conrad Lorenz		2. DATE AND HOUR OF DEATH	
				August 8, 1965 4:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224			Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 173 Center Street #21202		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
Male	White	Married	10-19-99	65	U. S. A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Paper Roller		Book binder		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John Lorenz			Anna Gunther		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		215-03-8833		RECORDS: BCH: 4940 Eastern Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO		
			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Tuberculosis, Alcoholism Years		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 7, 1965 to August 8, 1965, that (I) (we) last saw the deceased alive on August 8, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. Vincent Felitti				August 8, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Vincent Felitti		4940 Eastern Avenue Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/9/65		Greenmount	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 11 1965		Robert E. Felitti		J. F. Elmer Sons Reconstruction Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8329				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 8329	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
ZEITSCHEL, EMMA				Aug. 9, 1965		12:35		A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY			
St. Joseph Hospital				Maryland		A.A.Co.			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
				Pasadena,					
				D. STREET ADDRESS (If rural, give location)					
				Box 153-Laurel Drive- Route 6					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	
Female	White	Married	11-22-14	50					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Homemaker		Own home		Maryland		U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Samuel Windesheim				Emma Gurnroth					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT (husband)		ADDRESS	
no				unknown		Mr. Henry A. Zeitschel, Sr.		Same As #2	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)				(A) Carcinoma of breast, bilateral with wide spread metastasis to liver and partial obstruction of bile duct with jaundice.					
				(B) Bronchopneumonia right lower lobe.					
				(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2				Yes		Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from July 21, 19 65 to August 9, 19 65, that (I) (we) last saw the deceased alive on August 9, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Govinda Rao,								Aug. 9, 1965	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS			
						M.D. 1400 N. Caroline St., Baltimore, Maryland 21213			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		Aug. 12/65		Glen Haven Memorial Park		Glen Burnie, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
AUG 11 1965		Robert E. Fairbank		R.V. Singleton,		Glen Burnie, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8330				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8330	
1. NAME OF DECEASED (Type or Print) CHARLES REZIN HOPKINS				2. DATE AND HOUR OF DEATH AUGUST 5, 1965		10:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE 29, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY LINTHICUM C. CITY OR TOWN (If outside city limits, write RURAL and give township) LINTHICUM D. STREET ADDRESS (If rural, give location) 1308 FURNACE BRANCH RD. AVE.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 5-15-19	9. AGE (In years lost birthday) 46	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSTALLER		10B. KIND OF BUSINESS OR INDUSTRY STORM WINDOWS		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES E. Hopkins				14. MOTHER'S MAIDEN NAME ELIZABETH KING			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW 2		16. SOCIAL SECURITY NO. 215-1819732		17. INFORMANT ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.			
18. 3-870-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Acute Hemorrhagic Pancreatitis DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from AUGUST 5 19 65 to AUGUST 5 19 65 , that (I) (we) last saw the deceased alive on AUGUST 5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Edilberto Beltran				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-6-65	
23C. PHYSICIAN'S NAME (Type) EDILBERTO BELTRAN				23D. ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/9/65		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery,		24D. LOCATION (City, town, or county) (State) Brooklyn RFD Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1965		25B. NAME OF REGISTRAR Edilberto Beltran		25C. FUNERAL DIRECTOR ADDRESS Singleton Funeral Home, Glen Burnie, Md.			



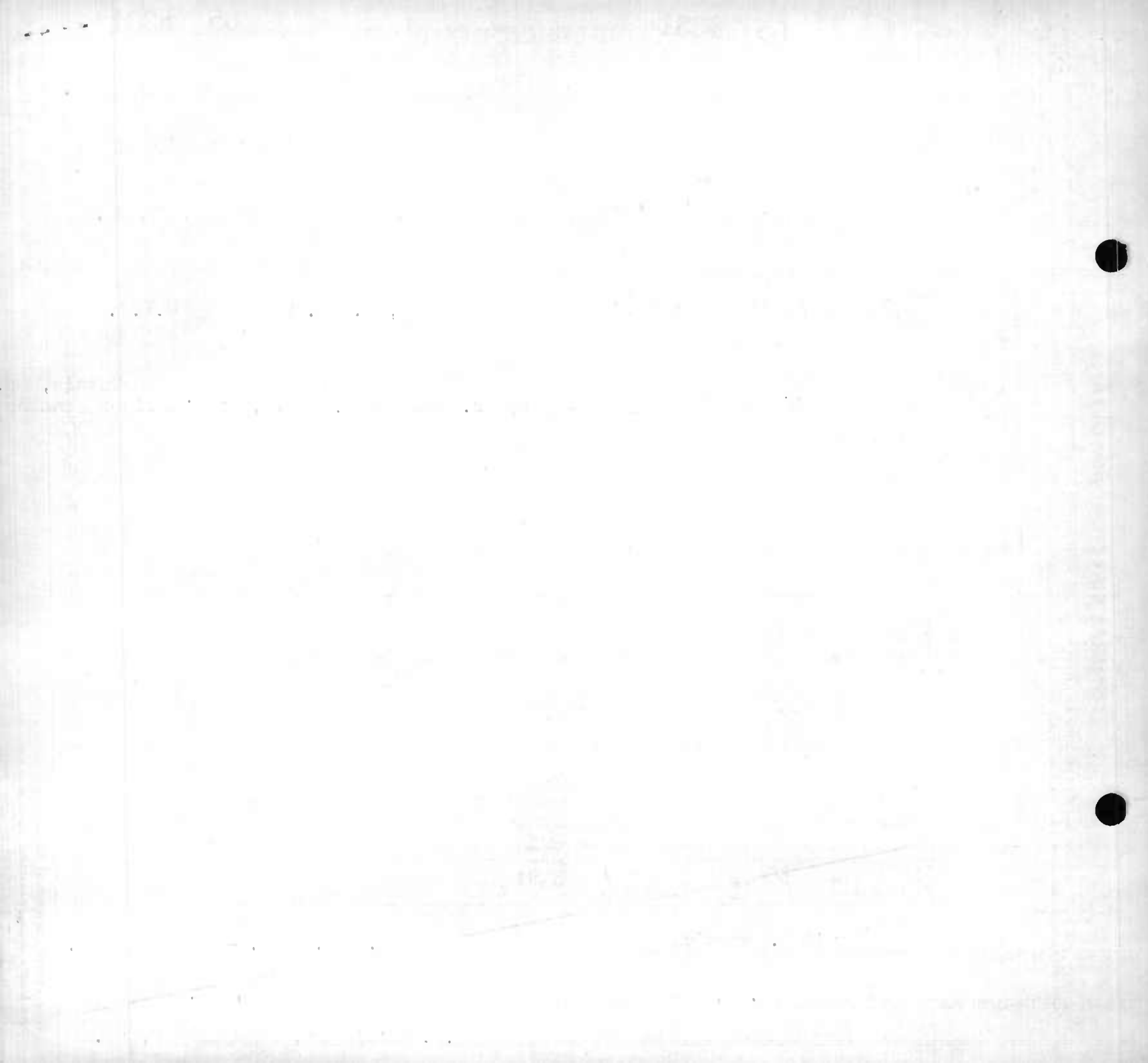
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

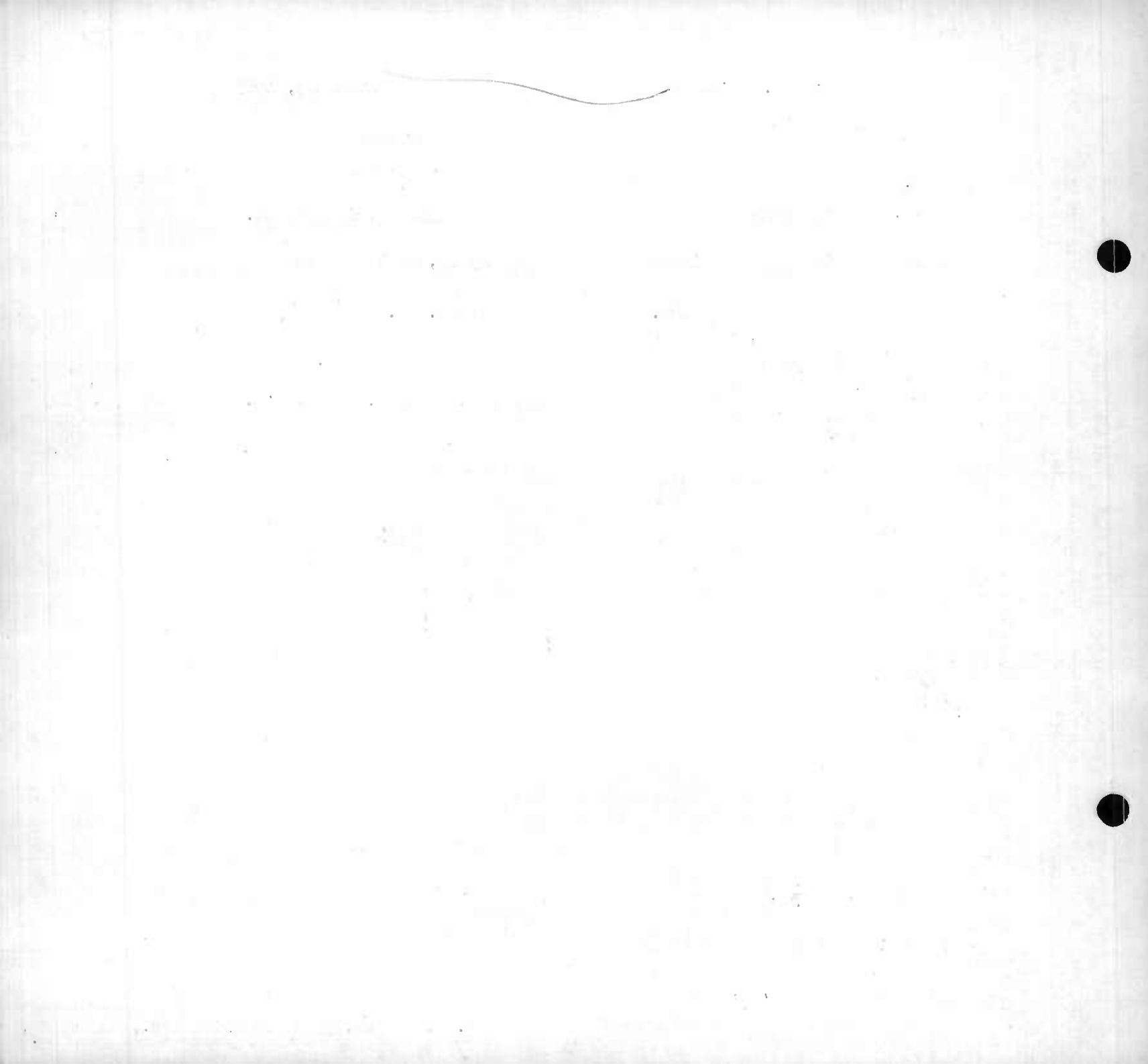
BALTIMORE CITY HEALTH DEPARTMENT				65 8331		Registered No. 65 8331	
BIRTH NO. 65 8331				CERTIFICATE OF DEATH			
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Uva Lilly		8/5/65 11:30 a. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location)				A. STATE Maryland		B. COUNTY	
South Baltimore General Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
				D. STREET ADDRESS (If rural, give location)		1010 Herndon Court Balto, 30, Md.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Female	White	Widow	9/12/07	57	INSPECTOR (RET)	HINTON, W. VA.	U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
ALBERT MEADOR				EMMA ENES			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				233-24-9963		Mr. Dolphus C. Lilly, 1007 Elkridge Landing	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				Myocardial Infarction			
ANTECEDENT CAUSES				DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 7/21/65 19 to 8/5/65 19, that (I) (we) last saw the deceased alive on 8/5/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Kermit P. Bonovich				8/5/65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Kermit P. Bonovich				South Balto. Gen. Hosp. - 1213 Light St.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		AUG. 9, 1965		GLEN HAVEN MEM PARK		GLEN BURNIE, MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 11 1965		R. V. SINGLETON		R. V. SINGLETON		GLEN BURNIE, MD.	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 8332		CERTIFICATE OF DEATH		Registered No. 65 8332	
1. NAME OF DECEASED (Type or Print) Albert A. Zimmerman				2. DATE AND HOUR OF DEATH August 9, 1965					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hood Nursing Home				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 20-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3140 Strickland St.					
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH May 16, 1897		9. AGE (In years lost birthday) 68		If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent of Sewers			10B. KIND OF BUSINESS OR INDUSTRY Balto. City		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Theodore Zimmerman				14. MOTHER'S MAIDEN NAME SE Caroline E. Eckerg					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 214-40-5835		17. INFORMANT Mrs. Betty M. Stout, 615. North Bend Rd. (29)				
18. 08231 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Viral Encephalitis DUE TO (B) Gumuly & Arterial Sclerosis DUE TO (C) Gumuly & Arterial Sclerosis				INTERVAL BETWEEN ONSET AND DEATH 2 months	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from July 15, 1965 to Aug 9, 1965 , that (I) (we) last saw the deceased alive on Aug 9, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Charles A Cahn				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/11-65			
23C. PHYSICIAN'S NAME (Type) Charles A CAHN				23D. ADDRESS 2045 W Baltimore St Balto Md					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 13, 65		24C. NAME of CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 12 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS G. T. Schwab, 3512 Frederick Ave., Balto 29, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8333	
BIRTH NO. 65 8333		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Charles T Kemp Jr		2. DATE AND HOUR OF DEATH Aug 8 1965 12:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home - Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland , B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Cockeysville D. STREET ADDRESS (If rural, give location) Bever Dam Road	
5. SEX M	6. RACE Cau	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 94 12-30-25
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) engineer		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 70
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles T. Kemp		14. MOTHER'S MAIDEN NAME Agnes Hardy	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT Betty Kemp ADDRESS Bever Dam Rd Cockeysville, Md.
18. 420.14581.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary myocardial infarction, acute (RT.)		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Super Carcinoma (Paen)	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from August 5 1965 to August 8 1965 , that (I) (we) last saw the deceased alive on August 8 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Ephraim B. Barzaga M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 8-9-65
23C. PHYSICIAN'S NAME (Type) EPHRAIM B. BARZAGA		23D. ADDRESS CHURCH HOME & HOSPITAL - BALTO. 31, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 8/11/65	24C. NAME OF CEMETERY or CREMATORY SHERWOOD	24D. LOCATION (City, town, or county) (State) COCKEYSVILLE, MD.
25A. DATE REC'D BY HEALTH DEPT. AUG 12 1965	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR ADDRESS H.W. MEARS & SON 805 N. CALVERT ST.	

1952
Aug 8

Church Home & Hospital
Beverly Hills
Cockeysville
Beverly Hills Road

11 Can married
12-15-52
Maryland
USA

Charles T. Kemp
Betty Kemp
Beverly Hills
Cockeysville

Residence Improvement
Superior (RT)

William (Garcia)

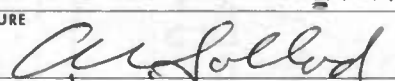
August 8
August 8

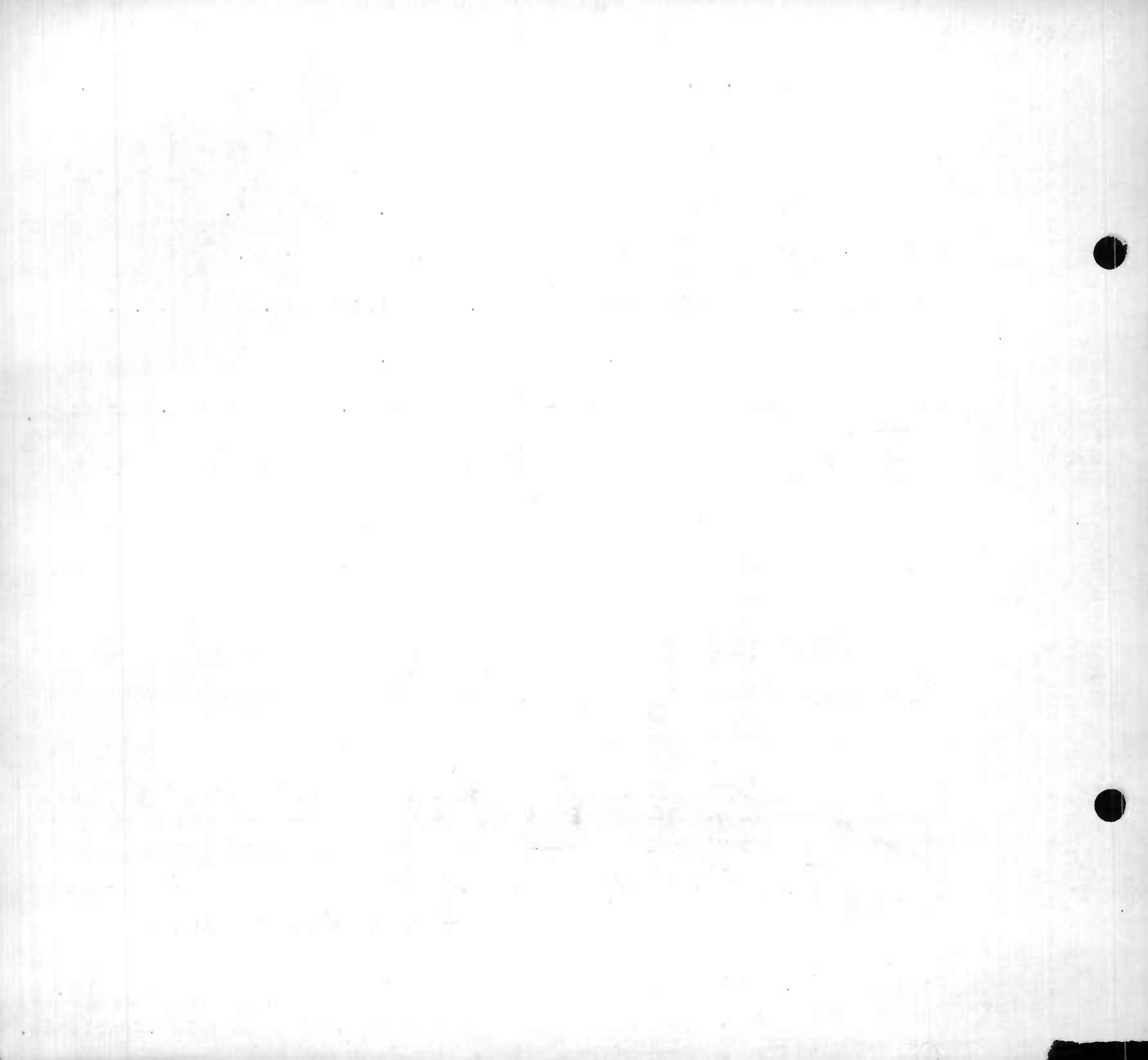
8-9-52

Epiphany B. BARRA
Church Home & Hospital - Baltimore

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

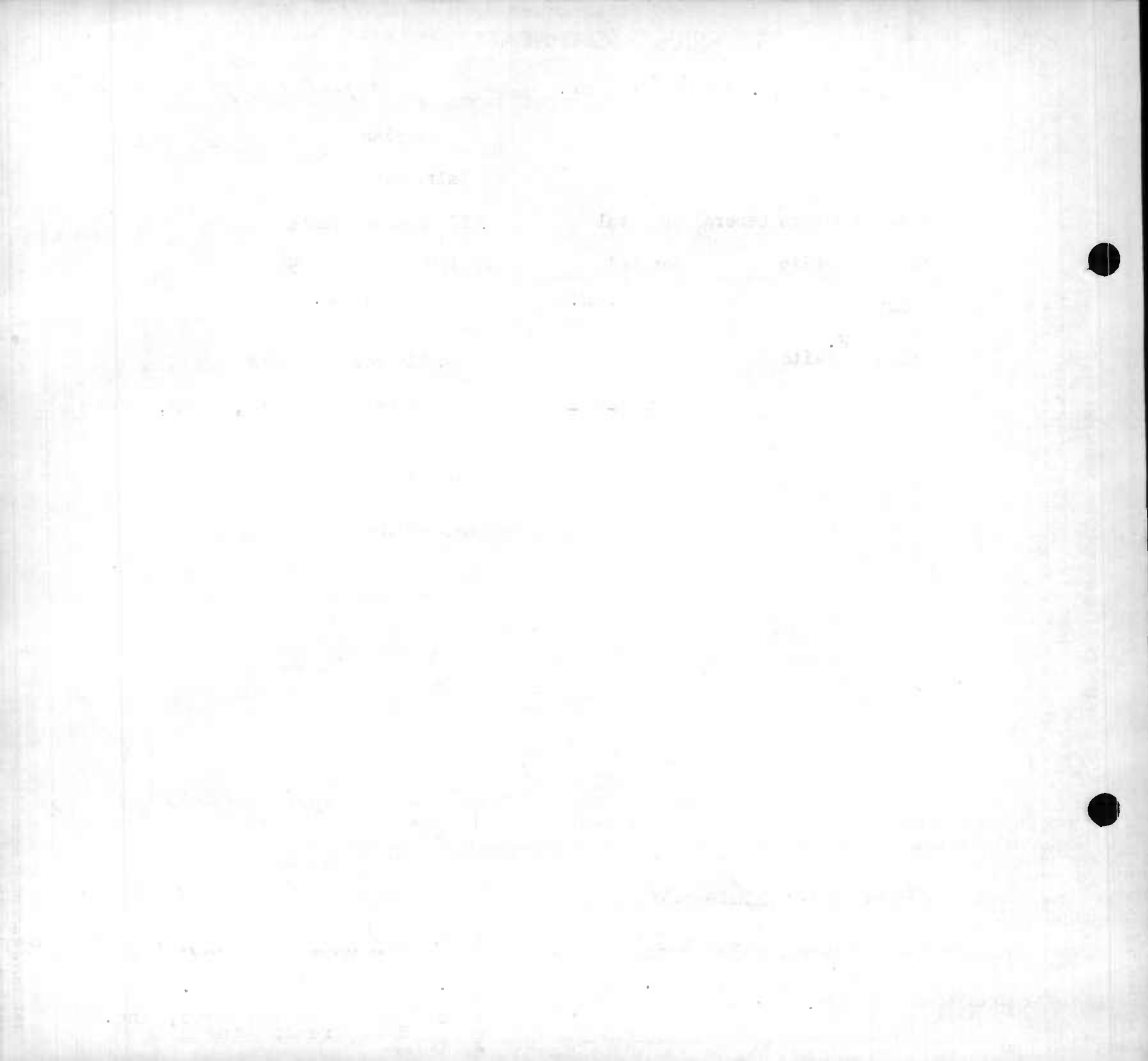
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65-8334	
BIRTH NO. 65 8334		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Howard F. O. Burke		2. DATE AND HOUR OF DEATH August 10, 1965 2 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1131 S. Charles St.			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH May 4, 1911	9. AGE (In years last birthday) 54yrs.	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lathe Operator		10B. KIND OF BUSINESS OR INDUSTRY Rubber Millers Inc. Baltimore Md,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Burke			14. MOTHER'S MAIDEN NAME Mary G.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-07-7640		17. INFORMANT ADDRESS Margaret M. Burke 1131 S. Charles St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I		CAUSE OF DEATH (A) Myocardial Infarction DUE TO (B) Arteriosclerosis DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 1 day 2 yrs. +	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 5, 1962 to Aug. 3, 1965 , that (I) (we) last saw the deceased alive on 8-3-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-11-65	
23C. PHYSICIAN'S NAME (Type) Robert E. Farber		23D. ADDRESS M.D. 707 E. FORT AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/13/65	24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 12 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS KRAUSE FUNERAL HOME 1216S. Charles St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

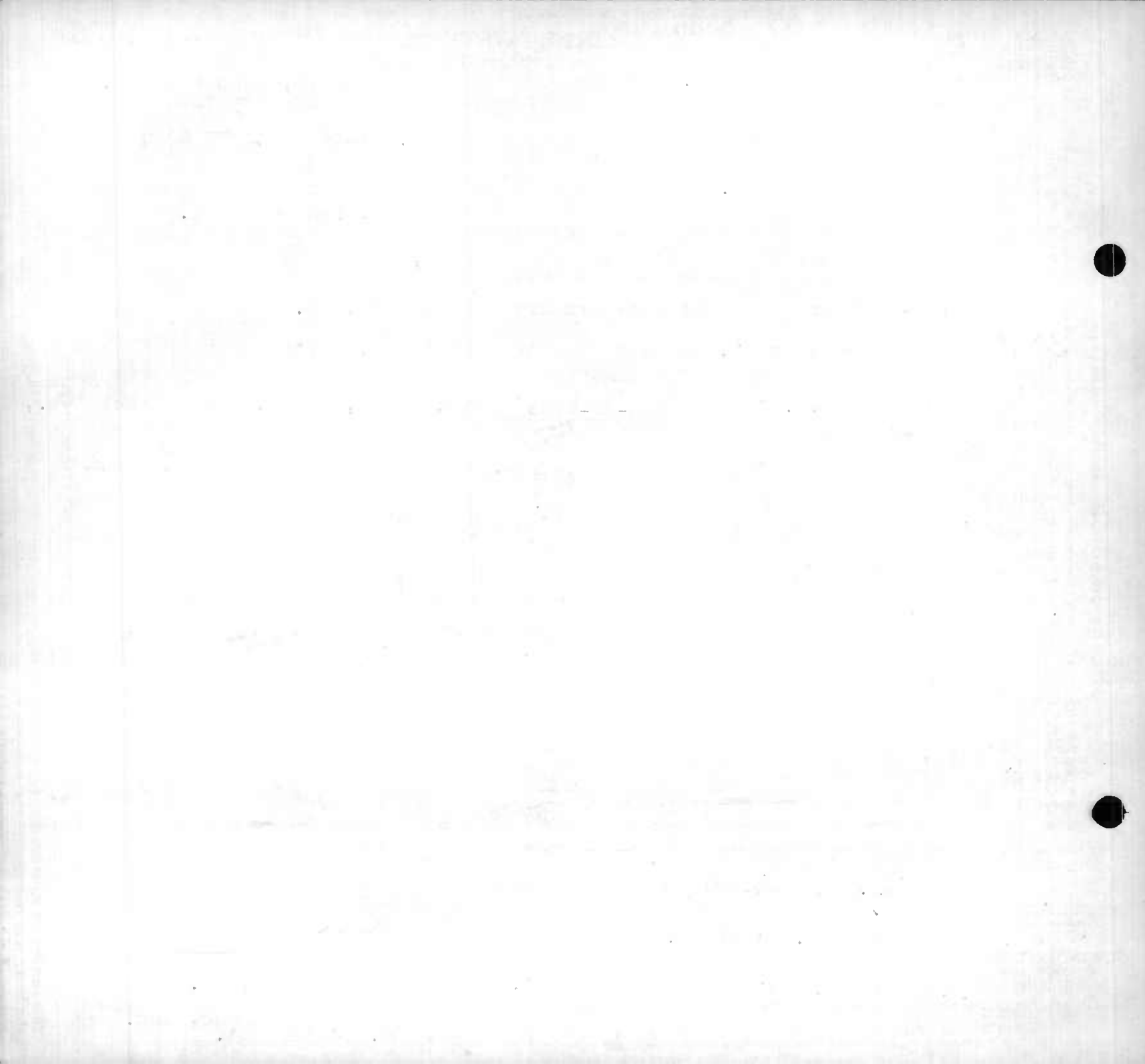
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 8335		CERTIFICATE OF DEATH		Registered No. 65 8335		
1. NAME OF DECEASED (Type or Print) Rolande F. Smith Sr.				2. DATE AND HOUR OF DEATH August 11, 1965 1:35 A. M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-03						
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital (If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3023 Brendan Avenue						
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2/21/09		9. AGE (In years last birthday) 56		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY B & O R. R.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME R. Roland Smith				14. MOTHER'S MAIDEN NAME Sophie Beckay Vukas						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 705-05-3518		17. INFORMANT Marie Stacks Smith, wife, above				ADDRESS	
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Carcinoma of lung ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. metastasis of ca of lung				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from July 27, 1965 to August 11, 1965 , that (I) (we) last saw the deceased alive on August 11, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Abdullah Samadi				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/11/65				
23C. PHYSICIAN'S NAME (Type) Samadi				23D. ADDRESS South Balto. Gen. Hosp. 1213 Light St. Balto						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/65		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT. AUG 12 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 3331 Brehms Lane				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8336		BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 65 8336	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WILLIAM W. COMEGYS		August 10, 1965 6 p. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE B. COUNTY			
(If not in hospital or institution, give street address or location)		Md. 21224			
90 Gould Conv. Home		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		137 N. Lakewood Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days Hours Min.
male	white	widowed	May 25, 1889	76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
ret- driver		National Brewery		Baltimore, Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William W. Comegys			Louise C. Kurtz		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Zone 14	
yes W.W. 1		215-03-7733		Esther Reid, sister, 4509 Weitzel Ave.,	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
450.0 I		Congestive Heart Failure		2 weeks	
ANTECEDENT CAUSES		(B) DUE TO		Chronic Arteriosclerosis	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		Left Hemiplegia due to stroke		months	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
0		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 7/2 19 65 to 8/10 19 65, that (I) lost saw the deceased alive on 8/7 19 65 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. Albert B. Bradley				8/11/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Albert B. Bradley				4900 Belair Road	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/14/65		Moreland Mem. Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 12 1965		Robert S. Feldman		Schimunek Funeral Home, Inc.	
25D. LOCATION (City, town, or county) (State)		ADDRESS			
Baltimore, Md.		2601 B. Madison St.			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LESTER N. SOUTHARD

2. DATE AND HOUR PRONOUNCED DEAD

August 6, 1965 1:05 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1829 N. Charles St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

9. AGE (In years last birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Hotel Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Waldorf Hotel

11. BIRTHPLACE (State or foreign country)

King Wm. Co. Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Willie Lee Southard

14. MOTHER'S MAIDEN NAME

Martha Ellen Norman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

June ann Stivers-Richmond Va.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type)

Rudiger Breitenecker

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-6-65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

8-10-65

23C. NAME OF CEMETERY or CREMATORY

St. Stephen's Cemetery

23D. LOCATION (City, town, or county) (State)

St. Stephen's Va.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 12 1965

Robert S. Fink

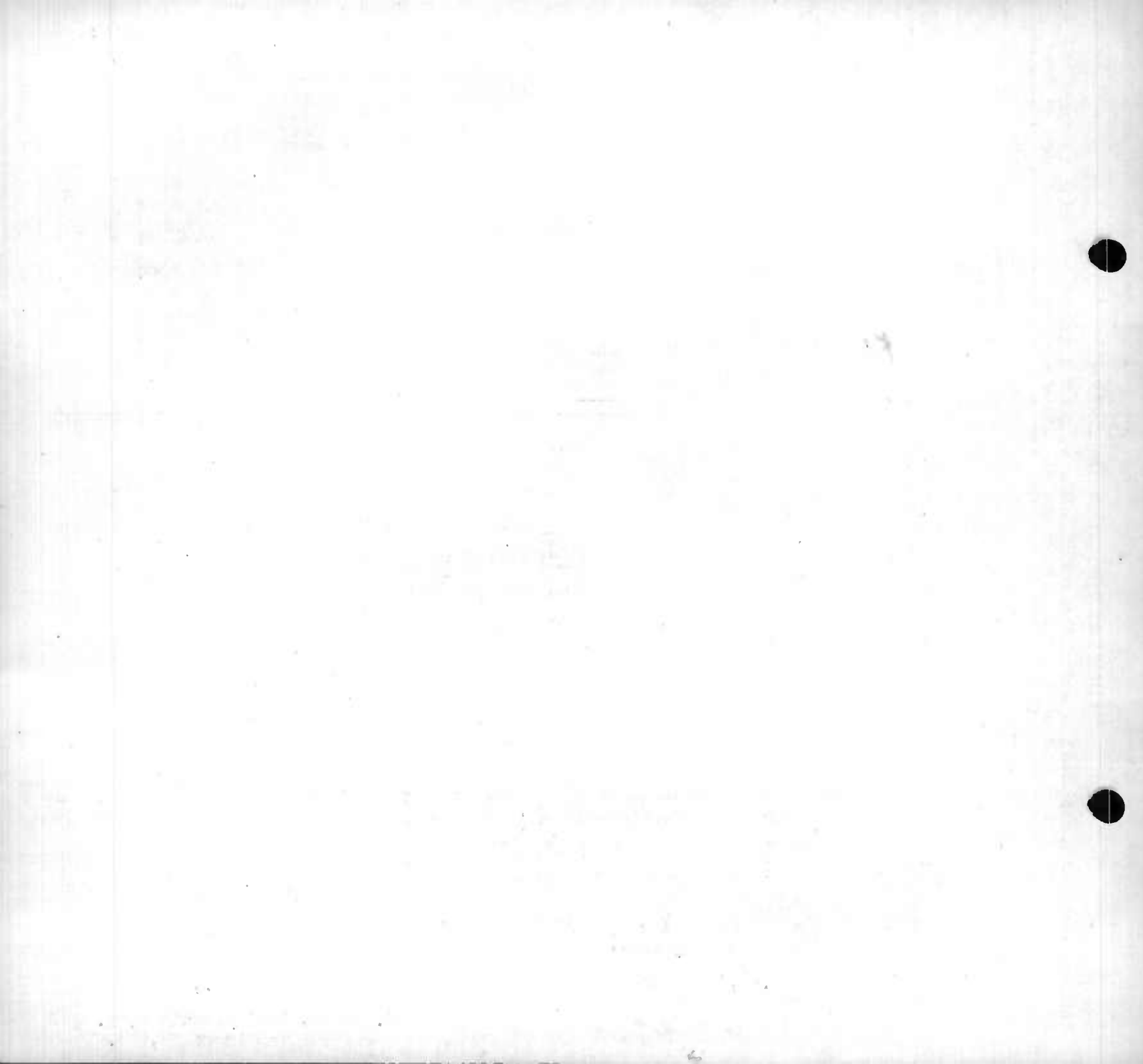
John C. Miller Inc. - 6415 Belair Rd.

WALTON POLICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

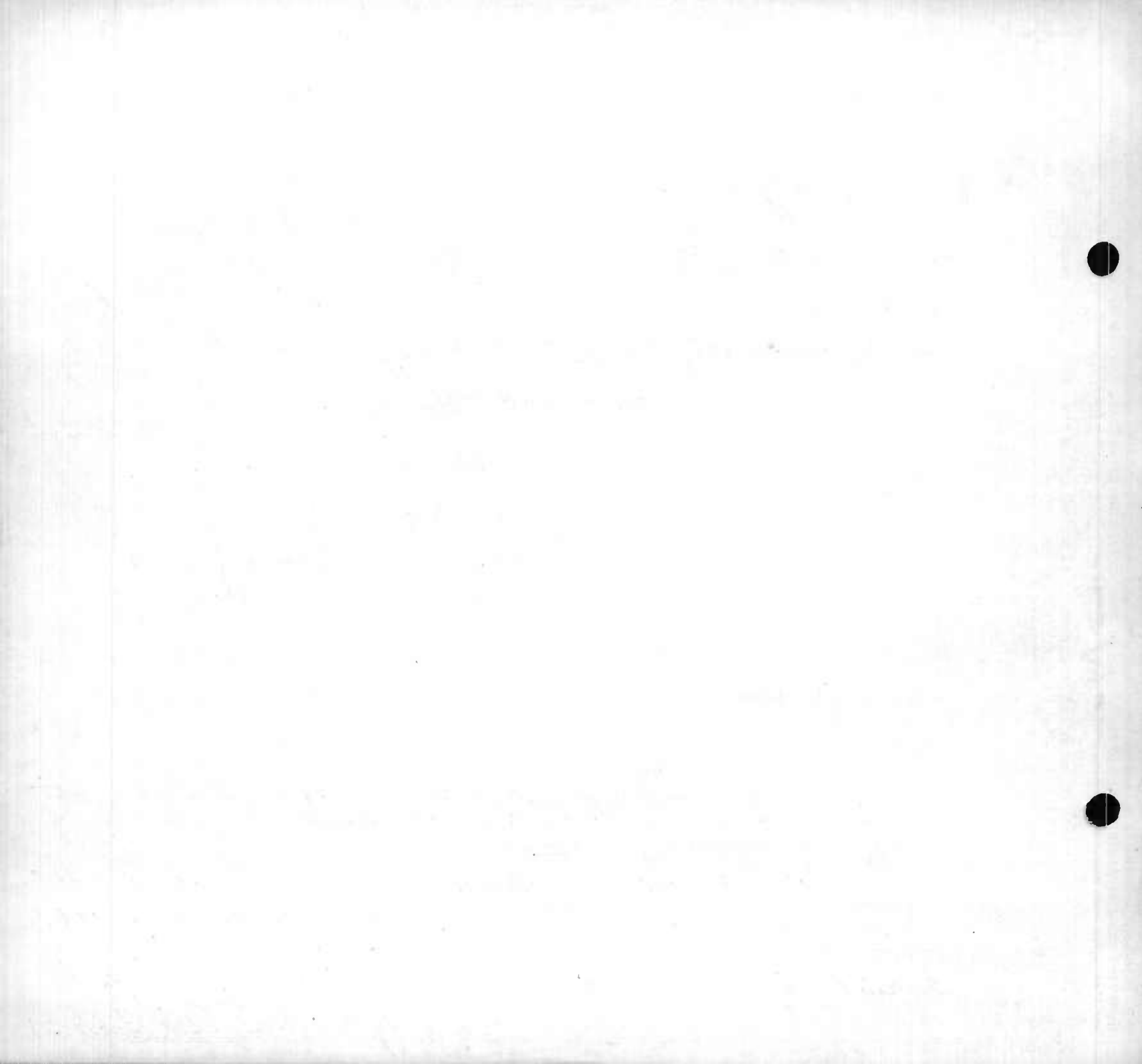
65 8338		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8338	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SYMCOWSKI, MARY	
2. DATE AND HOUR OF DEATH AUGUST 8, 1965		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL	
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED	
8. DATE OF BIRTH JAN 14 1884		9. AGE (In years last birthday) 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED	
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Stephen Kucho	
14. MOTHER'S MAIDEN NAME MAY		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. ----	
17. INFORMANT HOSPITAL RECORDS		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary of gall bladder fissure with metastatic to liver, and heart Pulmonary edema, acute Perforation of ascending colon		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 29 19 65 to August 8 19 65 , that (I) (we) last saw the deceased alive on August 8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rolando F. Del Rosario		M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-8-65	
23C. PHYSICIAN'S NAME (Type) ROLANDO F. DEL ROSARIO		M.D. <input type="checkbox"/>		23D. ADDRESS Franklin St. Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 11, '65		24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery	
24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 12 1965			
25B. NAME OF REGISTRAR George J. Gonce		25C. FUNERAL DIRECTOR ADDRESS 4001 Ritchie Hwy. Baltimore 25, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 8339		CERTIFICATE OF DEATH Registered No. 65 8339							
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HATTIE M. ENDRESS				2. DATE AND HOUR OF DEATH Aug. 5, 1965			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				M.			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE				B. COUNTY			
(If not in hospital or institution, give street address or location)		Md. Balto. Balto.							
31 Balto. City Hosp.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)				Balto. 24 6300			
		D. STREET ADDRESS (If rural, give location)				7200 A Eastern Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Female	White	Married	7/30/95	70 yrs	at home	Balto. Md.	U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
Henry Schwartzhaupt			Mary Schmick			16. SOCIAL SECURITY NO. 212-44-1290B			
			17. INFORMANT			ADDRESS			
			Husband (Same as above)						
18. 420.1		CAUSE OF DEATH						INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) acute myocardial infarction							
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(B) Coronary insufficiency							
ANTECEDENT CAUSES		(C) and aortic insufficiency							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				No.					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from Nov 30 1964 to Jun 16 1965 , that (I) (we) lost saw the deceased alive on Jun. 16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED			
R. Santayana						Aug. 7 - 65			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS							
RAFAEL A. SANTAYANA		6010 Eastern Ave. BALTO 24 Md.							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Burial		8/9/65		Oak Lawn		Balto. Co. Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
AUG 12 1965		Robert E. Taylor		Connelly		300 Mace Ave. Balto. 21			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8340				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 8340	
1. NAME OF DECEASED (Type or Print) Clara A Pieper				2. DATE AND HOUR OF DEATH August 10, 1965 12:10 A. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore					
FULL NAME OF HOSPITAL OR INSTITUTION Ardleigh Nursing Home				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Arbutus 63-00					
(If not in hospital or institution, give street address or location)				D. STREET ADDRESS (If rural, give location) 1316 Birch Ave					
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Sept. 8, 1880	9. AGE (in years last birthday) 84	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Gustav Pieper				14. MOTHER'S MAIDEN NAME Augusta Eichmann					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 21205-8890		17. INFORMANT Mary C. Pieper		ADDRESS 1316 Birch Ave	
18. #2211 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease				CAUSE OF DEATH (A) Arteriosclerotic cardiovascular disease (B) (C) INTERVAL BETWEEN ONSET AND DEATH 10 yrs.					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from October 19 60 to August 10, 19 65 , that (I) (we) last saw the deceased alive on August 6, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Lloyd E. Saylor				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/10/1965			
23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor				23D. ADDRESS M.D. 3902 Greenmount Ave.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/12/65		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 12 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Amstrong Inc		ADDRESS 1328 Sulphur Sp Rd			

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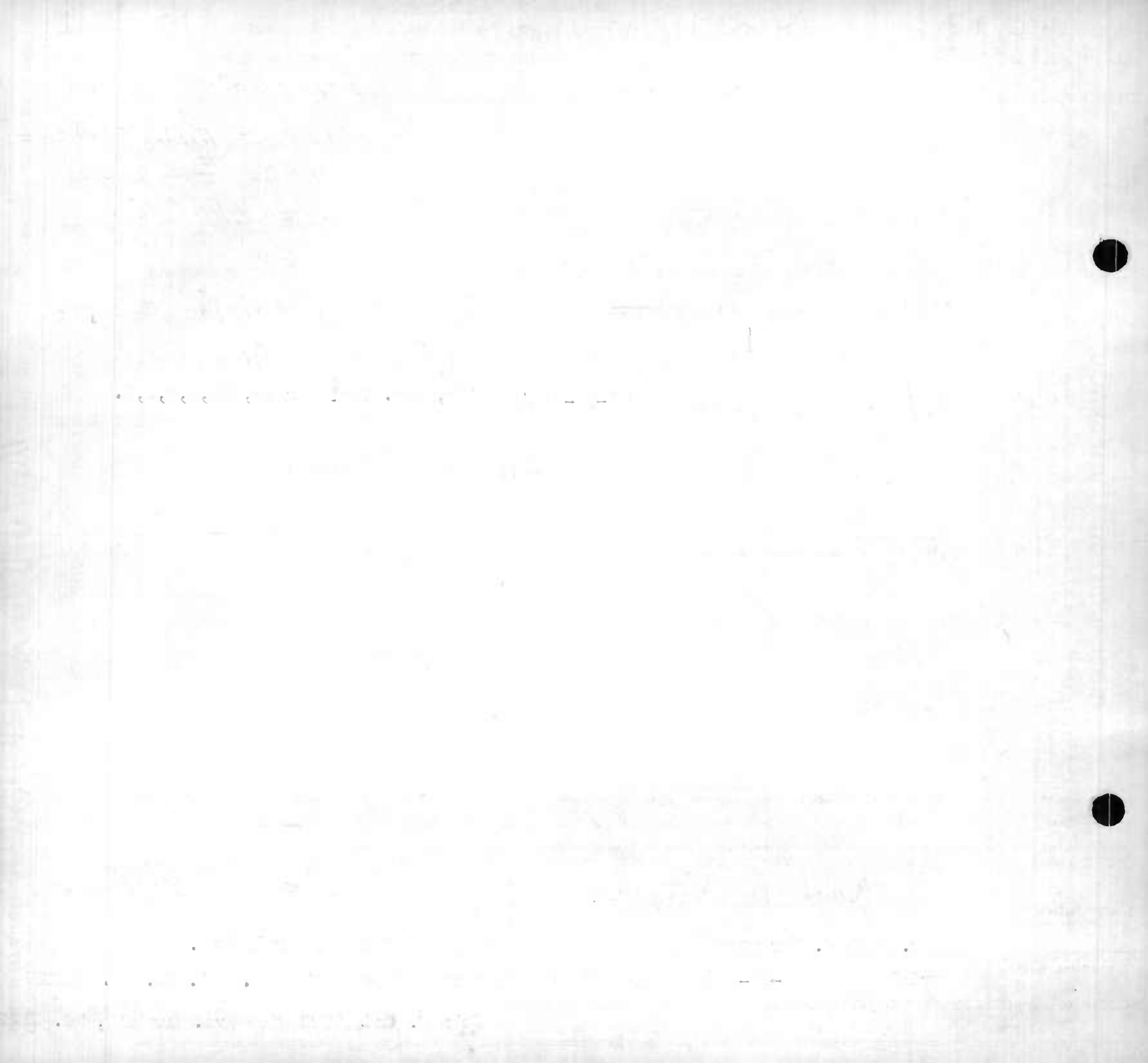
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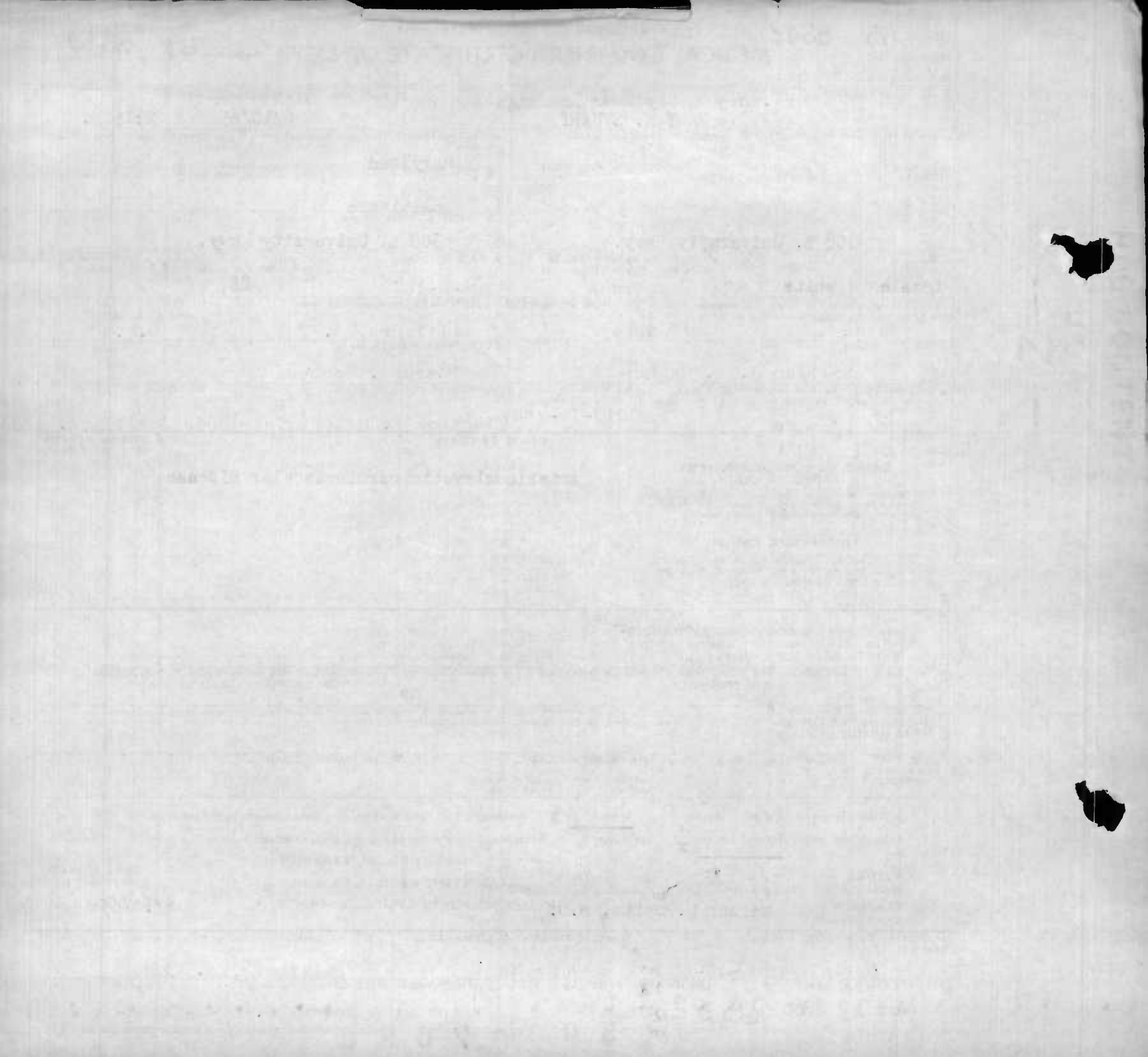
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 8341		CERTIFICATE OF DEATH		65 8341	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		Anthony Suder.		8-10-65 2:45 A.M.	
3. PLACE OF DEATH		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
BALTIMORE, MARYLAND		A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
South Baltimore General Hosp.		Maryland - BALTIMORE			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
M.		White		Married	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
8-9-1900		64		MECHANIC - GEN. EM. CO.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
West Virginia		U.S.A.		Andrew Suder	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Martha Kresser		Yes army - 1918		233-30-6514	
17. INFORMANT		18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Wife, Mrs. Tecla Suder, #4, a, b, c, d.		(A) Laennec's Cirrhosis			
		(B) DUE TO			
		(C) DUE TO			
		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
		(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			
		ANTECEDENT CAUSES			
		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
		II			
		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 7-30 19 65 to 8-10 19 65, that (we) last saw the deceased alive on 8-10 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
		Hugh J. Hargrave		8-10-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Hugh J. Hargrave		South Baltimore General Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8-13-1965		Sacred Heart of Jesus	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
German Hill Rd. Bal. Co. Md. 21222		John J. Duda		7922 Wise Ave. Dundalk, Md. 21222	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 12 1965		Robert E. Taylor		John J. Duda	



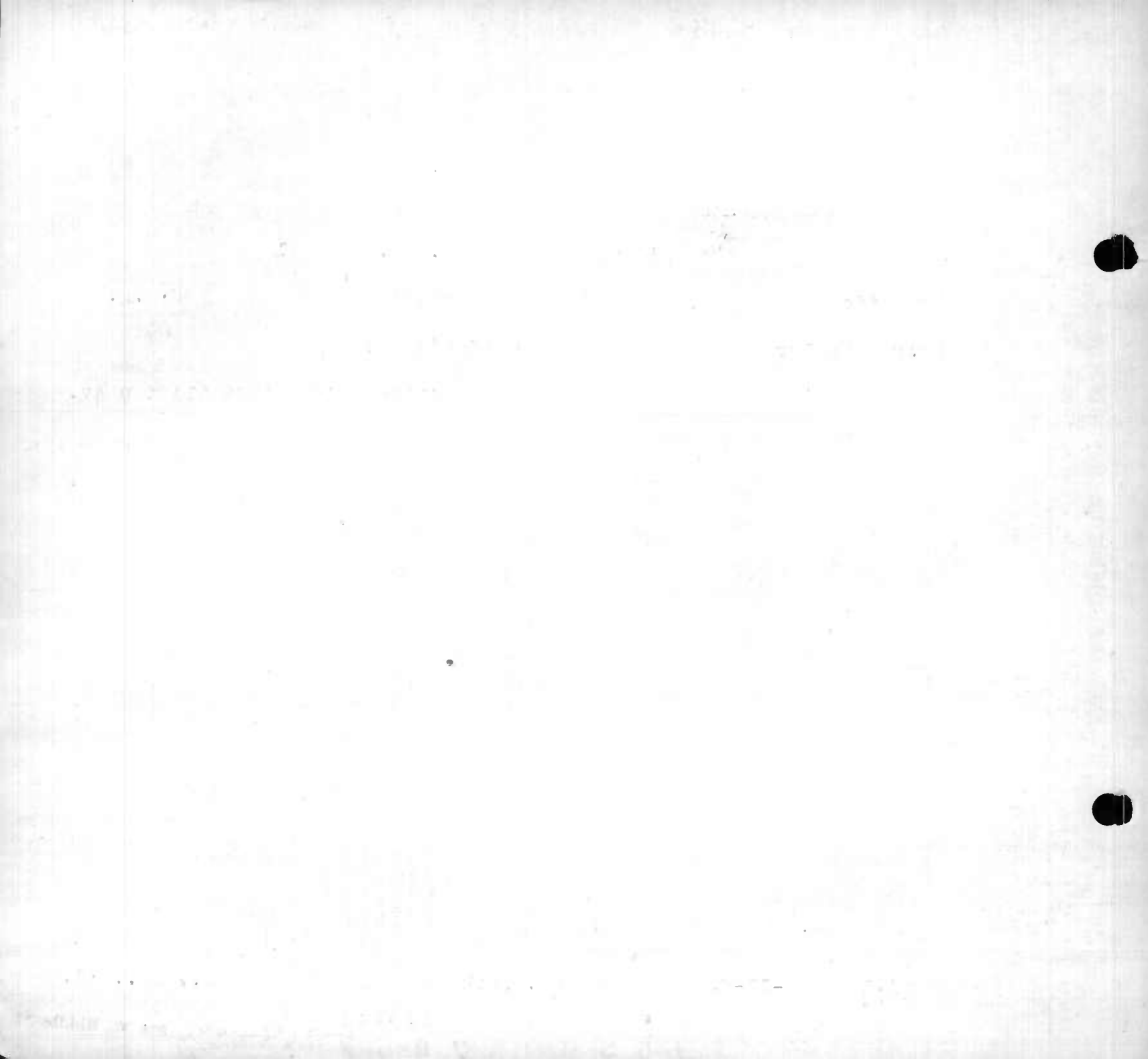
1		65 8342		BALTIMORE CITY HEALTH DEPARTMENT		65 8342	
BIRTH NO.				MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) Mrs. Mary Emily SeEVERS Hughes Stuart				2. DATE AND HOUR PRONOUNCED DEAD			
MARY E. STUART				8/10/65 2:15 p. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland			
308 E. University Pkwy.				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-2			
5. SEX female				6. RACE white			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow				8. DATE OF BIRTH Nov-9-1879			
9. AGE (In years last birthday) 85				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			
11. BIRTHPLACE (State or foreign country) Baltimore, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME William J. S. Hughes				14. MOTHER'S MAIDEN NAME Mary R. SeEVERS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 219-10-8607			
17. INFORMANT				ADDRESS			
Miss Mary F. Hughes (niece)				3049 Abell Ave. (18)			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				Arteriosclerotic cardiovascular disease			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) no				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 8/10/65							
23A. BURIAL CREMATION, REMOVAL (Specify) burial				23B. DATE Aug-13-65			
23C. NAME of CEMETERY or CREMATORY GreenMount				23D. LOCATION (City, town, or county) (State) Baltimore, Md. 21202			
24A. DATE REC'D BY HEALTH DEPT. AUG 12 1965				24B. NAME OF REGISTRAR Robert E. Farley, M.D.			
24C. FUNERAL DIRECTOR				ADDRESS			
Stewart & Mowen Co.				108-W-North-Av-21201			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8343				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8343	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Laura Medley</u>				2. DATE AND HOUR OF DEATH <u>8-8-65</u> <u>12:18 A.</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
<u>Box-Wil-Ba Convalescent Home</u>				<u>Md.</u> <u>16-09</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				<u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location)			
				<u>1509 N. Ellamont St.</u>			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		
<u>F.</u>	<u>Col.</u>	<u>Widowed</u>	<u>Feb. 21, 94</u>	<u>71</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Domestic</u>				<u>Virginia</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George Taylor</u>				<u>Mimmie ?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
				<u>Mr Willie Smith</u>		<u>1802 Clifton Av.</u>	
18. <u>420.0 I</u> CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH							
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) <u>Arteriosclerotic heart disease</u>			
ANTECEDENT CAUSES				DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<u>0</u>				<u>No</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1-29-</u> <u>1962</u> to <u>8-8-</u> <u>1965</u> , that (I) (we) last saw the deceased alive on <u>8-6-</u> <u>1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
<u>C.R. Campbell</u>						<u>8-8-65</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
<u>C.R. Campbell</u>				<u>M.D. 1618 W. North Ave.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-11-65</u>		<u>Arbutus Mem. Park</u>		<u>Arbutus Balto., Co., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME of REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
<u>AUG 12 1965</u>		<u>Robert E. Jackson</u>		<u>Dr. Francis A. H. H. H.</u>		<u>578 W. Middle St.</u>	



BIRTH NO. 65 8344		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 8344	
M.E. CASE NO. 7-256					
1. NAME OF DECEASED (Type or Print) RICHARD F. TESCHNER			2. DATE AND HOUR PRONOUNCED DEAD 8-11-65 11:39 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 700 FLEET STREET			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pennsylvania B. COUNTY Chester C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Chester D. STREET ADDRESS (If rural, give location) 230 E. 5th Street		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 12, 1915	9. AGE (In years last birthday) 52	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman - Seaman		10B. KIND OF BUSINESS OR INDUSTRY Merchant Marine		11. BIRTHPLACE (State or foreign country) Illinois	
13. FATHER'S NAME Fred Teschner			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) No			14. MOTHER'S MAIDEN NAME ??		
16. SOCIAL SECURITY NO. 324-07-7532			17. INFORMANT Beatrice Teschner - 2207 E. Pratt St.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Probable drowning ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Harbor		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Unknown (Found in harbor)	
21D. TIME OF INJURY (APPROX.) FOUND: 8 11 '65 AM		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Unknown (Found in harbor)	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) RUDIGER Breitenecker, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8-11-65	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 8/12/65		23C. NAME OF CEMETERY or CREMATORY St. Stanislaus	
24A. DATE REC'D BY HEALTH DEPT. AUG 12 1965		24B. NAME OF REGISTRAR Robert E. Farley		24C. FUNERAL DIRECTOR George A. Weber - 705 S. Ann St.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		24E. ADDRESS George A. Weber - 705 S. Ann St.			

WALLLEY FORD

FUNERAL DIRECTOR: IMPORTANT

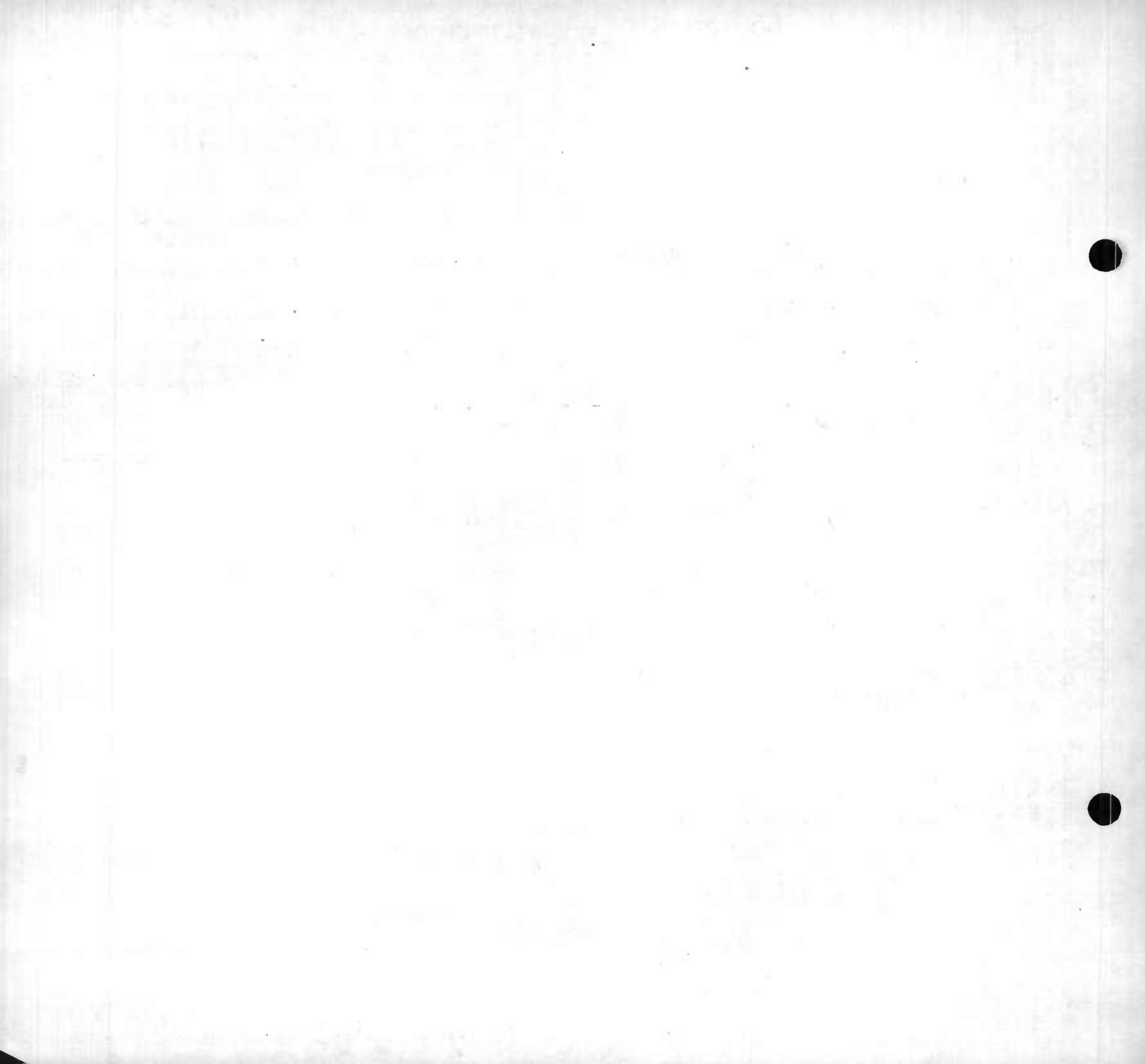
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 8345					CERTIFICATE OF DEATH					Registered No. 65 8345				
M.E. CASE NO. 65 8345					1. NAME OF DECEASED PHEBE D. TUTTLE					2. DATE AND HOUR OF DEATH 8-9-65 7 05 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					5. CITY OR TOWN (If outside city limits, write RURAL and give township)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE MARYLAND					B. COUNTY Baltimore				
Union Memorial Hospital					TOWSON					#4 63-00				
D. STREET ADDRESS (If rural, give location)					DULANEY TOWSON					NURSING HOME				
6. SEX F		7. RACE W		8. MARRIAGE STATUS WIDOWED		9. DATE OF BIRTH 4-4-91		10. AGE (In years lost birthday) 74		11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) NEW YORK				
13. FATHER'S NAME WILLIAM DILLINGHAM					14. MOTHER'S MAIDEN NAME MERZA BUTLER					15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None				
16. SOCIAL SECURITY NO. 212-05-6718					17. INFORMANT SON AR. SAMUEL TUTTLE					ADDRESS 503 HATHERLEIGH RD. #12				
18. 572.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES					DUE TO DIVERTICULITIS - RUPTURED									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					DUE TO ASTHMATIC BRONCHITIS & ACUTE EXACERBATION									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) No				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (we) (this hospital) attended the deceased from 7-28-65 to 8-9-65, that (we) lost saw the deceased alive on 8-9-65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (view) the body after death.														
23A. SIGNATURE J. Z. Hsu					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED Aug. 9, 1965				
23C. PHYSICIAN'S NAME (Type) ZUTZANG HSU					M.D. Union Memorial Hosp.									
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation					24B. DATE 8/13/1965					24C. NAME OF CEMETERY or CREMATORY London Park Crematory				
24D. LOCATION Baltimore, Maryland														
25A. DATE REC'D BY HEALTH DEPT. AUG 12 1965					25B. NAME OF REGISTRAR Robert E. Farkas					25C. FUNERAL DIRECTOR Wm. J. Farkas & Sons Baltimore, Md. 21217				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8346		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 8346	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Ellsworth Long			2. DATE AND HOUR OF DEATH August 9, 1965 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 15-10 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3809 Boarman Avenue 21215		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Nov. 17, 1877	9. AGE (In years last birthday) 87	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Physician		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Westminster, Md.	
13. FATHER'S NAME Miles L. Long			14. MOTHER'S MAIDEN NAME Mary Jane Zimmerman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 184-05-8054		17. INFORMANT Mr. A. David Gomborov 730 Equitable Building Baltimore, Md. 21202 ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Arterio Sclerotic Heart Disease (B) Massive Aorta - Aneurysm (C) Chronic Emphysema		INTERVAL BETWEEN ONSET AND DEATH 10-30 yrs. 10 yrs. 5 yrs. 6 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized Arterio Sclerotic Disease - 5 yrs.					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 3, 1950 to Aug. 9, 1965, that (I) (we) last saw the deceased alive on Aug. 9, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Earl L. Chambers			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/10/65
23C. PHYSICIAN'S NAME (Type) Earl L. Chambers			23D. ADDRESS M.D. 4106 Liberty Hts Balto. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/12/1965		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 12 1965		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Nymphaeas & Sons Balto., Md. 21217 ADDRESS North-Pow. Ave.	



1
M-265

65 8347

BALTIMORE CITY HEALTH DEPARTMENT

65 8347

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BRIDGET MARY McCORMACK

2. DATE AND HOUR PRONOUNCED DEAD

8-11-65

7:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

LUTHERAN HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2230 Garrison Blv'd

16

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

April 4, 1879

9. AGE (In years
last birthday)

86

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ireland

12. CITIZEN OF
WHAT COUNTRY?
U. S. A.

13. FATHER'S NAME

William Morkan

14. MOTHER'S MAIDEN NAME

Ellen Sheehan

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

3824 Beech Ave.
Mr. Bernard A. McCormack Baltimore, Md. 11

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORK

NOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-11-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/14/1965

23C. NAME OF CEMETERY or CREMATORY

New Cathedral Cemetery

23D. LOCATION

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

AUG 12 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Wm. J. Fickman & Son North Pa. Ave.
Baltimore, Md. 21217

VALLEY FORCE

RADICANT

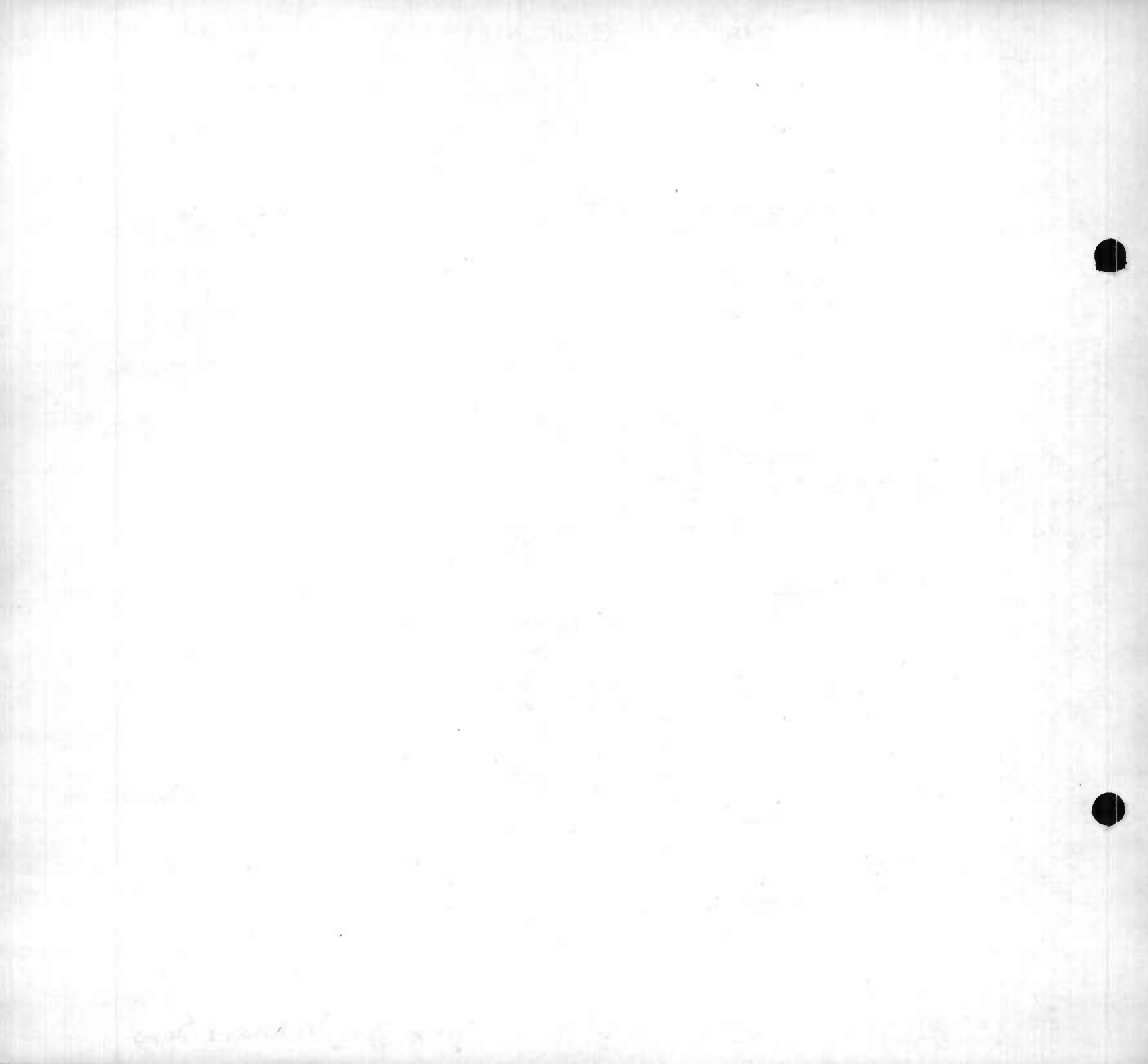
128

11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

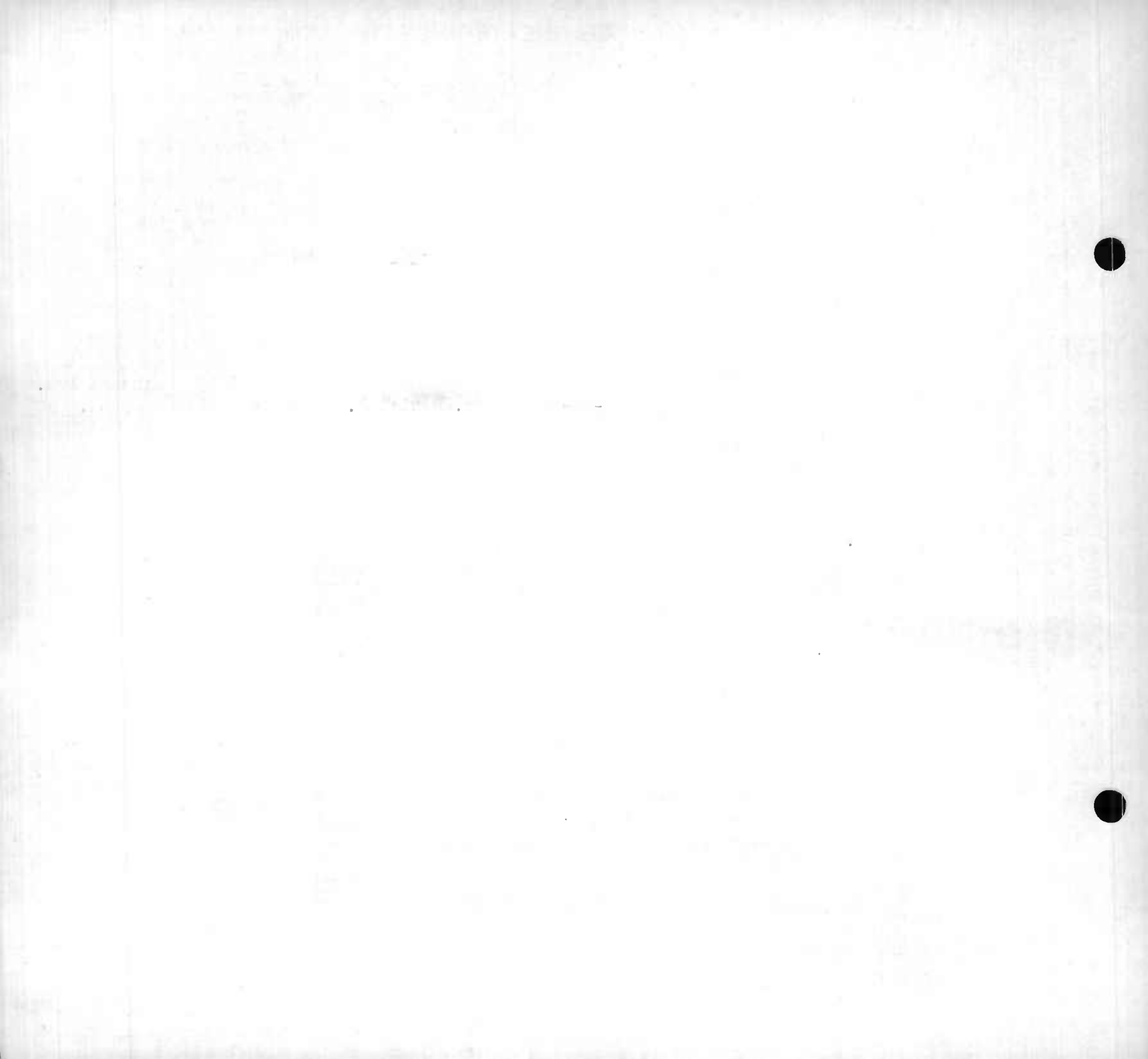
BIRTH NO. 65 8348				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8348	
M.E. CASE NO. 65 8348				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Gertrude A. Pfeiffer				2. DATE AND HOUR OF DEATH August 9, 1965			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 28-04			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hood Nursing Home 5313 Edmondson Ave. Baltimore, Maryland 21229				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 5313 Edmondson Ave. 21229			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Nov. 11, 1879	9. AGE (In years last birthday) 85	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Hood Nursing Home Records		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 422.1 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Longevity Failure				CAUSE OF DEATH (A) Cerebral Arterio Sclerosis DUE TO (B) A. S. C. V. D. DUE TO (C) 2 yrs		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10-1-63 19 to 8-9-65 19, that (I) (we) last saw the deceased alive on 8-9-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE James H. Stowers				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-11-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D. Pikesville			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/11/1965		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 12 1965		25B. NAME OF REGISTRAR P. L. E. F. J. J. J.		25C. FUNERAL DIRECTOR J. W. J. J. J. J. J. J. J. J. J.		ADDRESS J. W. J. J. J. J. J. J. J. J. J.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

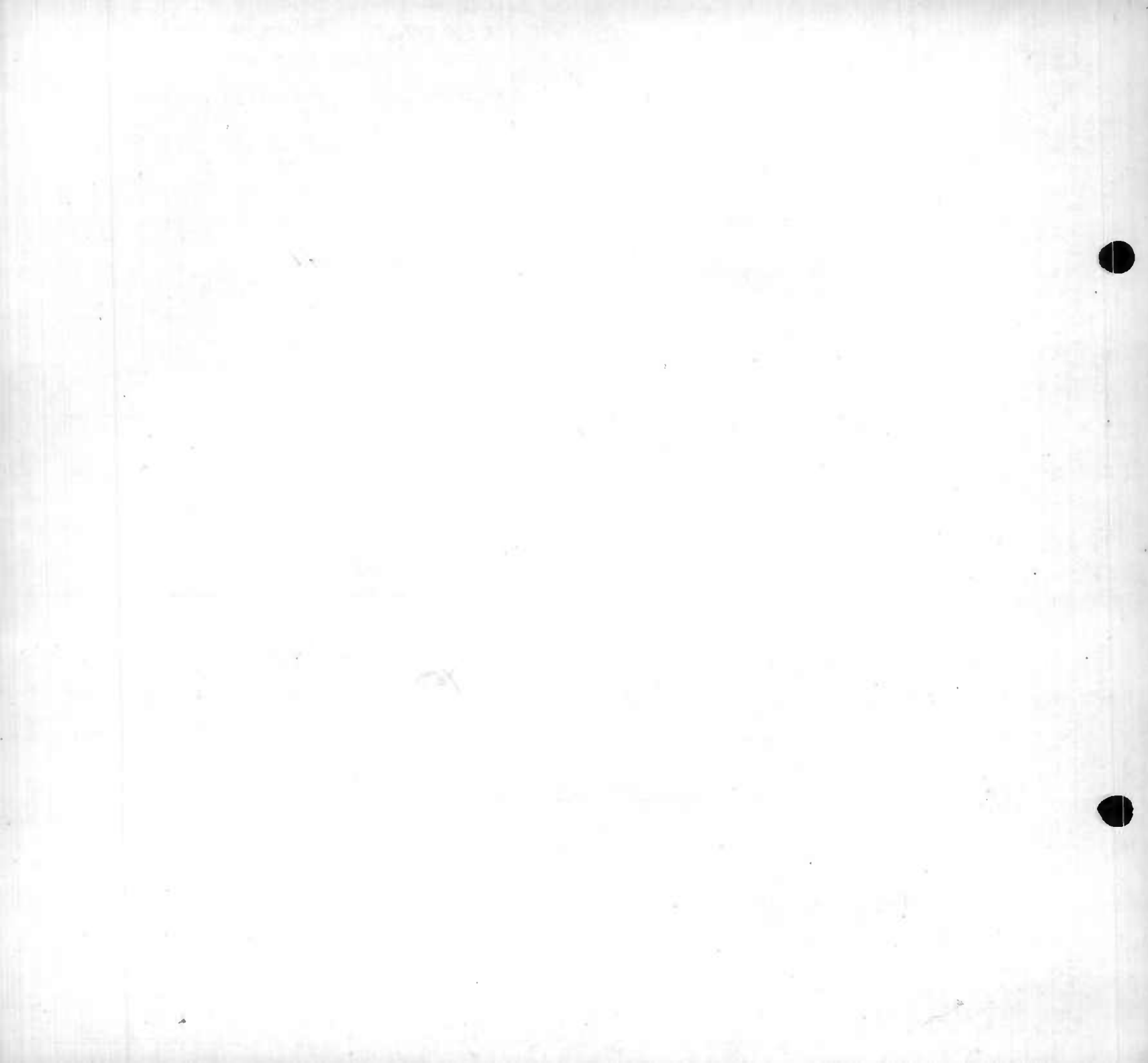
BIRTH NO.		65 8349		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8349	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Valencia, Helen Gertrude</i>			
2. DATE AND HOUR OF DEATH <i>8-10-65</i>				3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>44</i>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>25-42</i>				5. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
6. STREET ADDRESS (If rural, give location) <i>2575 Southdene. Ave. 30</i>				7. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>North Charles General Hosp</i> <i>2724 N. Charles St</i>			
8. SEX <i>Female</i>		9. RACE <i>White</i>		10. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		11. DATE OF BIRTH <i>12/1/1919</i>	
12. AGE (In years last birthday) <i>45</i>		13. If Under 1 Yr. Months Days		14. If Under 24 Hrs. Hours Min.		15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Meat wrapper</i>	
16. KIND OF BUSINESS OR INDUSTRY <i>Eddie Super Market</i>		17. BIRTHPLACE (State or foreign country) <i>West Virginia</i>		18. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		19. FATHER'S NAME <i>William Golden</i>	
20. MOTHER'S MAIDEN NAME <i>Nellie Num</i>		21. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <i>No</i>		22. SOCIAL SECURITY NO. <i>228-16-5249</i>		23. INFORMANT <i>Mr. Daniel J. Valencia - Baltimore, Md. 30</i>	
24. ADDRESS <i>2575 Southdene Ave.</i>		25. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>CARCINOMATOSIS</i>		26. INTERVAL BETWEEN ONSET AND DEATH		27. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.	
28. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		29. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <i>0</i>		30. CONDITION FOR WHICH OPERATION WAS PERFORMED		31. AUTOPSY? (Yes or No)	
32. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		33. 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		34. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		35. 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
36. 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		37. 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		38. 21F. HOW DID INJURY OCCUR?		39. 22. I certify that (I) (this hospital) attended the deceased from <i>8-10-65</i> 19 to <i>8-10-65</i> 19, that (I) (we) lost saw the deceased alive on <i>8-10-65</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
40. 23A. SIGNATURE <i>Valerio Incianga Jr M.D.</i>		41. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		42. 23B. DATE SIGNED <i>8-10-65</i>		43. 23C. PHYSICIAN'S NAME (Type) <i>WALTER ROHN M.D.</i>	
44. 23D. ADDRESS <i>102 E. FORT AVE</i>		45. 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		46. 24B. DATE <i>8/13/1965</i>		47. 24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National Cemetery</i>	
48. 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		49. 25A. DATE REC'D BY HEALTH DEPT. <i>AUG 12 1965</i>		50. 25B. NAME OF REGISTRAR <i>Robert E. Fagan</i>		51. 25C. FUNERAL DIRECTOR <i>Joseph J. Fagan & Son</i>	
52. ADDRESS <i>Baltimore, Md. 21217</i>		VS 150-REV. 1/1/65					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				BIRTH NO. 65 8350		Registered No. 65 8350	
1. NAME OF DECEASED (Type or Print) MARGIE Witherspoon				2. DATE AND HOUR OF DEATH August 11, 1965 11:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Lutheran Hospital of Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore B. COUNTY 20-02			
5. SEX F 6. RACE C 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married				8. DATE OF BIRTH 10/21/23		9. AGE (In years lost birthday) 41	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) PINE LEVEL N.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME W. H. DAVIS			
14. MOTHER'S MAIDEN NAME MITTIE BARNES				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT FRED L. WITHERSPOON 2150 W. Lexington St				ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 138.01 Pulmonary Sarcoidosis (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH Respiratory		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO			
(B) DUE TO				(C) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 8/11/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/3 1965 to 8/11 1965 , that (I) (we) last saw the deceased alive on 8/11 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Inia C. Espina				M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/11/65	
23C. PHYSICIAN'S NAME (Type) INIA C. ESPINA				23D. ADDRESS Lutheran Hospital of Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 8/14/65		24C. NAME OF CEMETERY or CREMATORY Pine Level N.C.		24D. LOCATION (City, town, or county) (State) Pine Level N.C.	
25A. DATE REC'D BY HEALTH DEPT. AUG 12 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Thompson & Sons		ADDRESS 638 N. Baltimore St	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

Registered No. 65 8351

BIRTH NO. 65 8351

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Agnes Teresa Falter

2. DATE AND HOUR OF DEATH

August 11, 1965 9:18 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

2912 Oakcrest Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Balto.

D. STREET ADDRESS (If rural, give location)

2912 Oakcrest Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Jan. 11, 1875

9. AGE (In years
last birthday)

90

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pitts., Penna.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Augustus Miller

14. MOTHER'S MAIDEN NAME

Bertha Ryan

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Miss Helen Falter

ADDRESS

Same

1B. 422-1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular
Disease

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.INTERVAL BETWEEN
ONSET AND DEATH

20 yrs (+)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

None

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

None

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

None

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At ☐ Not-White
Work ☐ At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 24 Nov 1948 to 11 Aug 1965,
that (I) (we) last saw the deceased alive on 8 Aug 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Edward L. J. Molz

M.D.

Attending
Phys.Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

11 Aug 65

23C. PHYSICIAN'S
NAME (Type)

Edward L. J. Molz M.D.

23D. ADDRESS

7425 Harford Rd. Balto., 34 Md

24A. BURIAL CREMATION
REMOVAL (Specify)

Burial

24B. DATE

8/14/65

24C. NAME of CEMETERY or CREMATORY

New Cathedral Cemetery

24D. LOCATION

(City, town, or county)

(State)

Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 12 1965

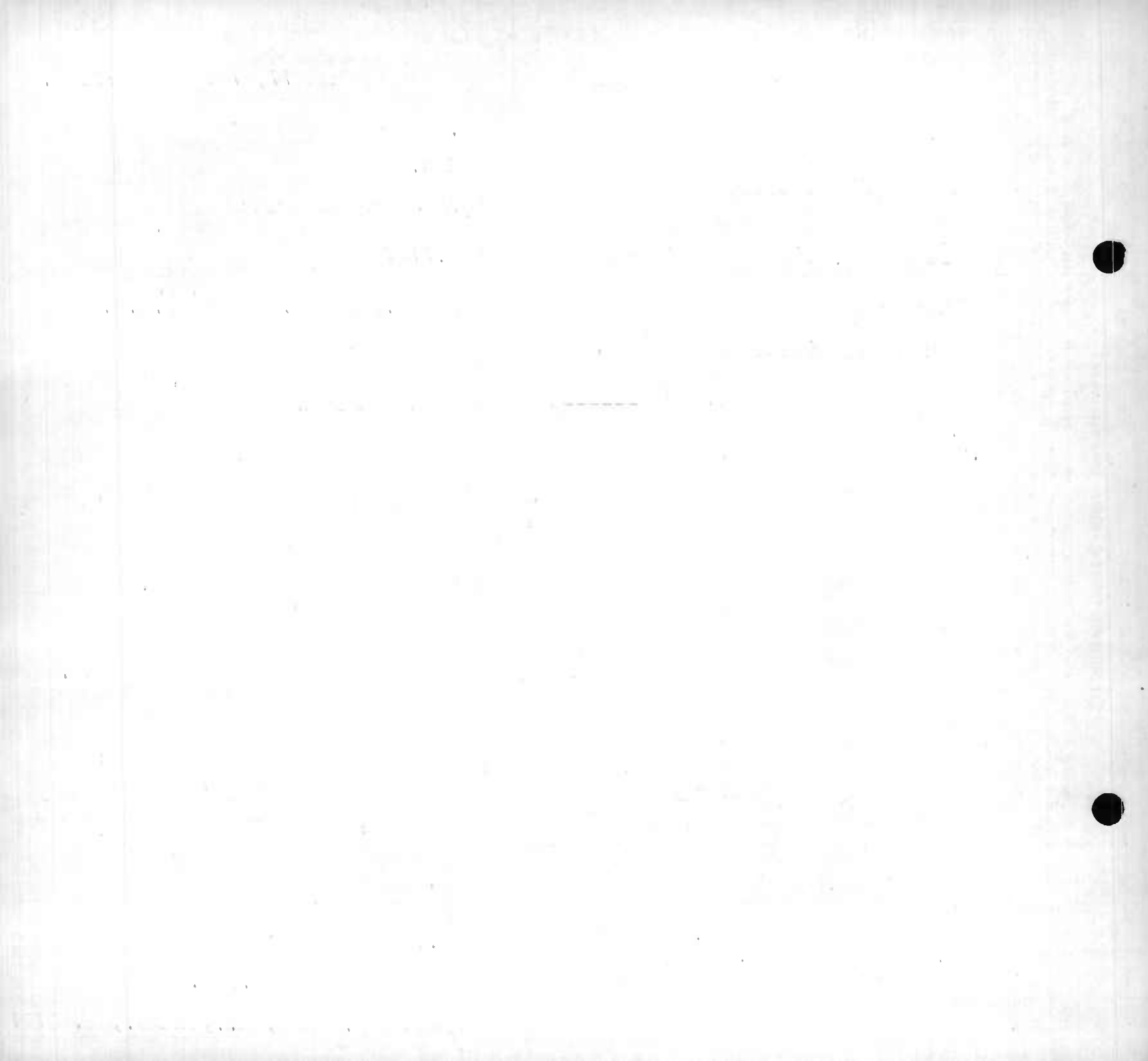
25B. NAME OF REGISTRAR

Robert E. Farber

25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc., Balto., Md. 21214

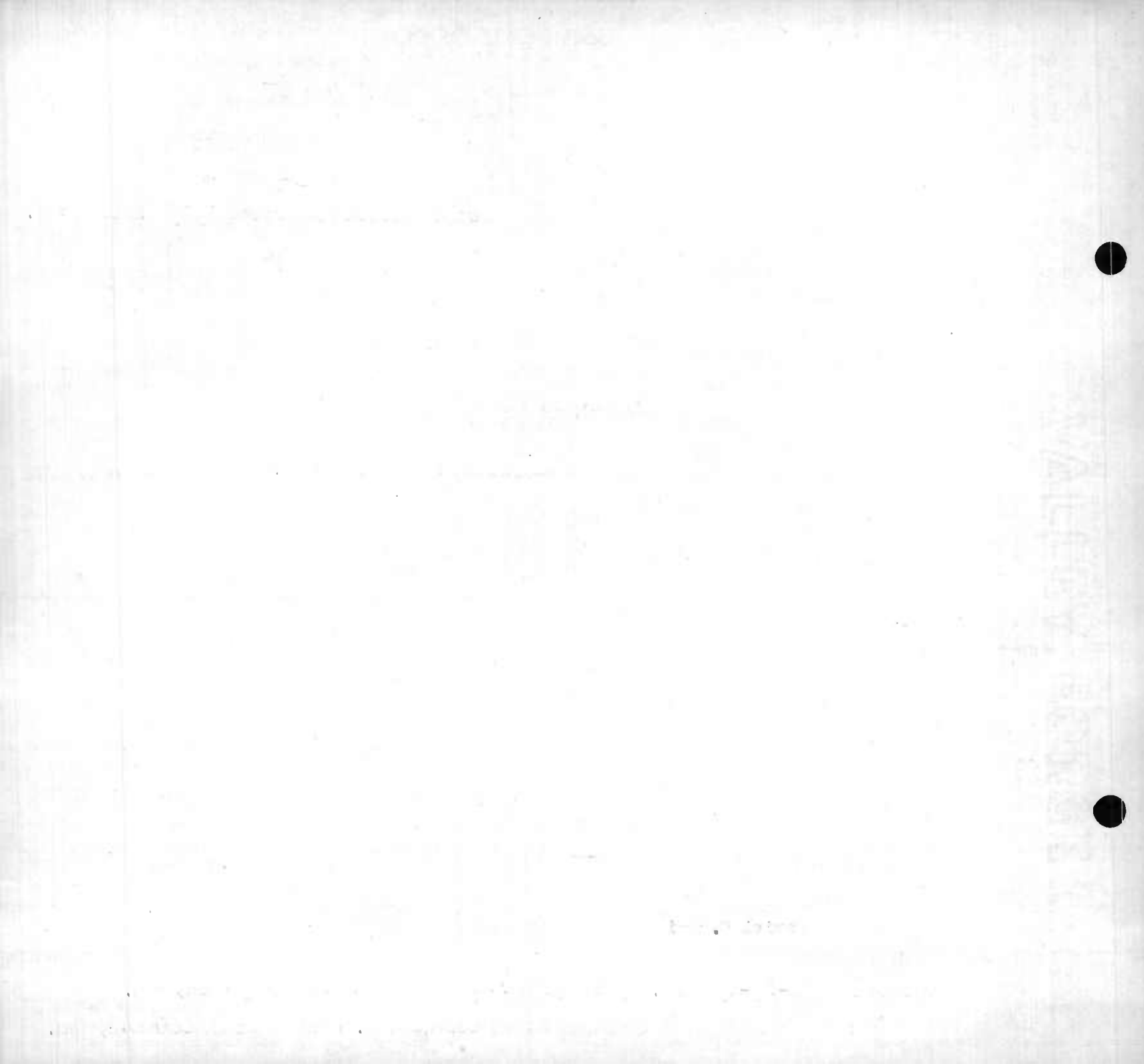
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8352		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8352	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) O'Connor, James Arthur		2. DATE AND HOUR OF DEATH 8/11/65 12:20 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION Monte Selo State Hospital		A. STATE Maryland		B. COUNTY Harford	
(If not in hospital at institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Edgewood		D. STREET ADDRESS (If rural, give location) 531 Kennedy Road 2525 Hanson Rd.	
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 3/15/1901	9. AGE (In years last birthday) 64	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Currenter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Michael O'Connor		14. MOTHER'S MAIDEN NAME Mary Doyle	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-09-8552		17. INFORMANT Hospital Records	
18. 191.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Squamous Cell Carcinoma of left face with metastasis		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 5 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		MEDICAL CERTIFICATION	
19A. DATE OF OPERATION 7/27/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 7/27/65 19 to 8/11/65 19		that (I) (we) last saw the deceased alive on 8/11/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Daniel G. Lai		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/11/65	
23C. PHYSICIAN'S NAME (Type) Daniel G. Lai		23D. ADDRESS 2201 Argonne Dr. Baltimore 16, Md.		24A. BURIAL CREMATION, REMOVAL (Specify) burial	
24B. DATE 8-14-65		24C. NAME of CEMETERY or CREMATORY Mt. Erin Cemetery		24D. LOCATION (City, town, or county) (State) Havre de Grace, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 12 1965		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8353	
BIRTH NO. 65 8353				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MARY J. ^{Josephine} Williams			2. DATE AND HOUR OF DEATH AUGUST 11 1965 9:31 AM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 9-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1837 E. 30TH STREET		
5. SEX F	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 12/6/91	9. AGE (In years last birthday) 73	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			11. BIRTHPLACE (State or foreign country) BALTIMORE, MD		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME THOMAS FREDERICK ZINNE			14. MOTHER'S MAIDEN NAME MARY BURGESS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 213280764		17. INFORMANT THOMAS WILLIAMS
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Myocardial Infarction DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 8 days		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 8/3/65 to 9:31 AM 8/11/65 and that the (we) lost saw the deceased alive on 9:31 AM 8/11/65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. the (We) (did) not view the body after death.					
23A. SIGNATURE Robert N. Whitlock				23B. DATE SIGNED 8/11/65	
23C. PHYSICIAN'S NAME (Type) Robert E. Farley MD				23D. ADDRESS Legnard J. Ruck Inc Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 8-14-65		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. STATE Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 12 1965		25B. NAME OF REGISTRAR Robert E. Farley MD		25C. FUNERAL DIRECTOR Legnard J. Ruck Inc Baltimore, Md.	

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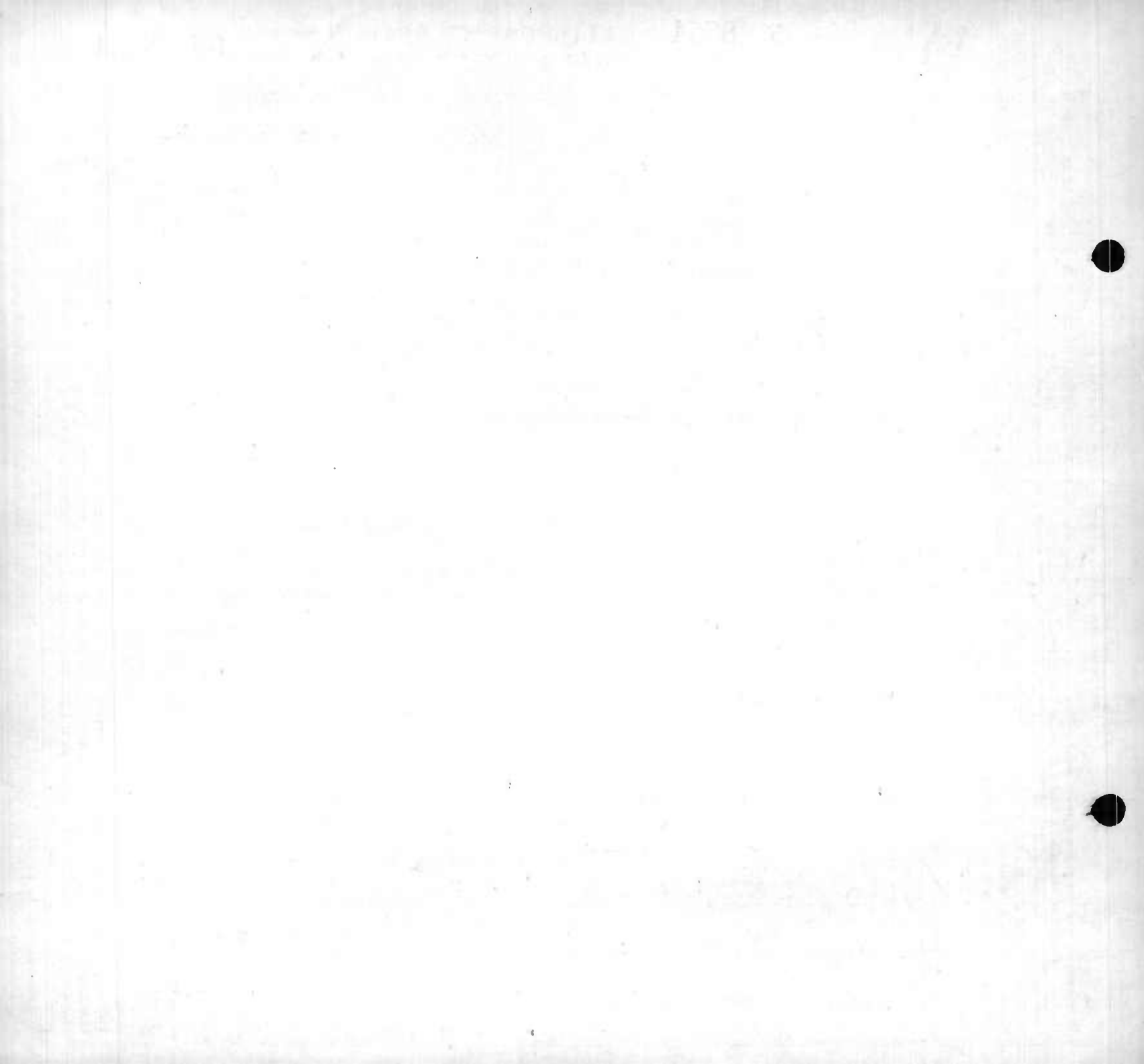
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

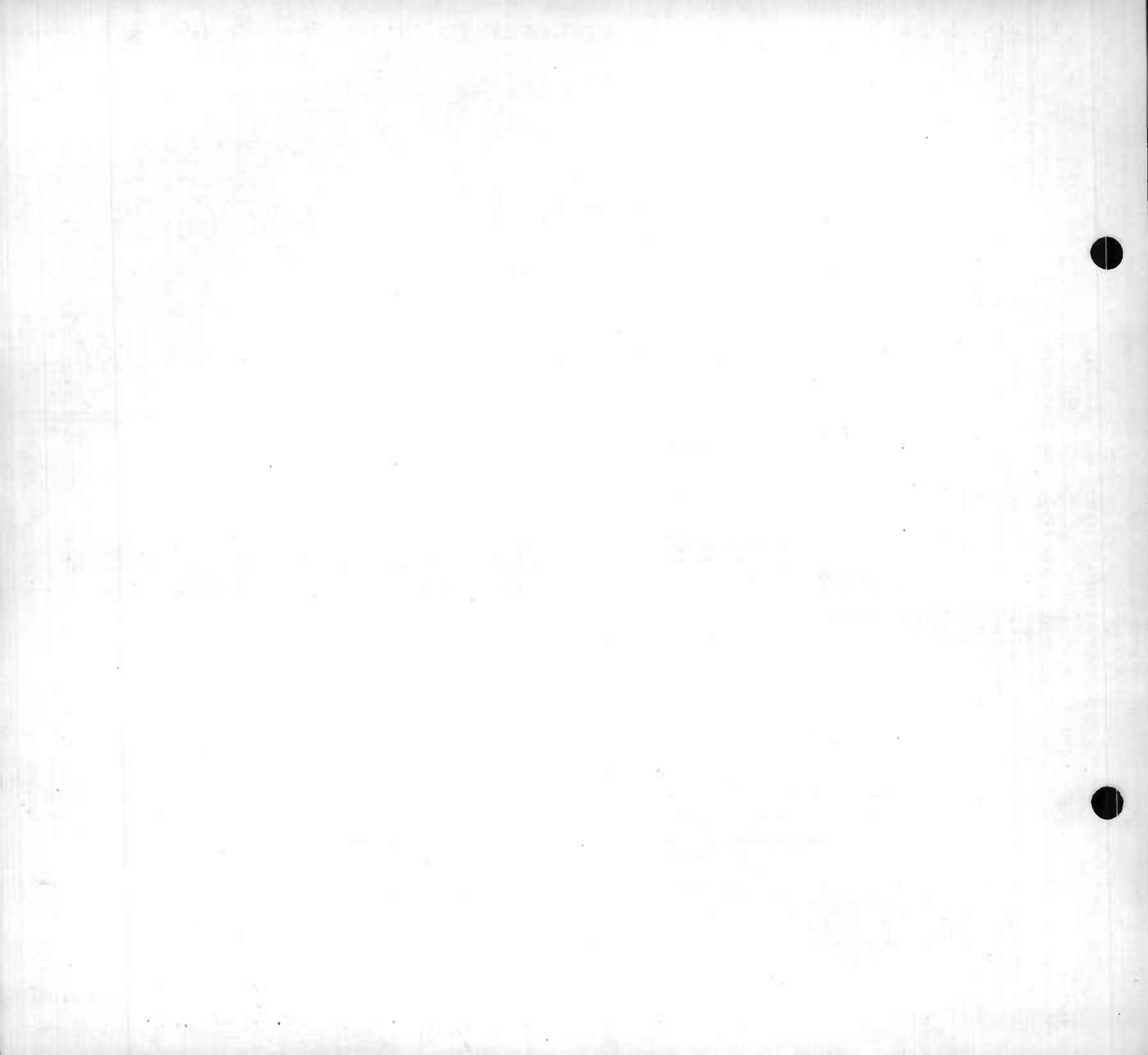
BIRTH NO. 65 8354				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8354	
1. NAME OF DECEASED (Type or Print) ALFRED GILGENAST				2. DATE AND HOUR OF DEATH August 3, 1965 3:20 p. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF INSTITUTION 90 CENTURY NURSING HOME		(If not in hospital or institution, give street address or location) 102 N. PACA ST.		A. STATE MARYLAND		B. COUNTY ANNE ARUNDEL	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) GLEN BURNIE 52-00			
				D. STREET ADDRESS (If rural, give location) 207 NORMAN AV.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED		8. DATE OF BIRTH SEPT. 7, 1895	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) NANTICOTE, PENN.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN GILGENAST				14. MOTHER'S MAIDEN NAME BERTHA GILGENAST			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 165-20-3516		17. INFORMANT EDWARD U. GILGENAST		ADDRESS 207 NORMAN AV. GLEN BURNIE, MD.	
18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Cardio-Respiratory Failure DUE TO Arteriosclerotic CVD (B) Carcinoma of Colon DUE TO (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Sept 28 1964 to Aug 3 1965 , that (I) (we) last saw the deceased alive on Aug 3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE William D Applefeld M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/3/65	
23C. PHYSICIAN'S NAME (Type) William D Applefeld				23D. ADDRESS 5501 Park Heights Rd. Baltimore, Maryland			
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal		24B. DATE 9 Aug 65		24C. NAME of CEMETERY or CREMATORY Anatomical Board		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 12 1965		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

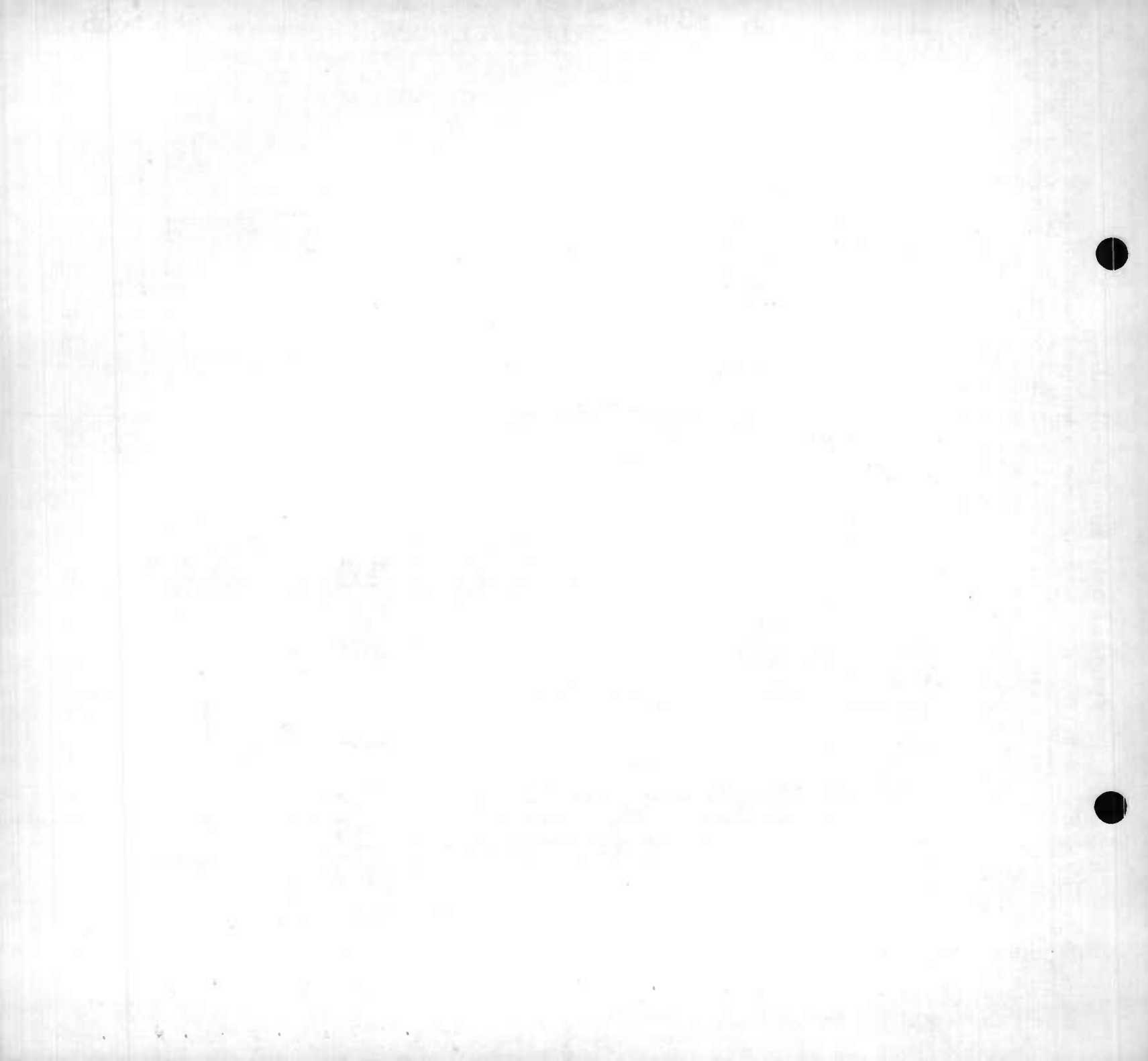
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		65 8355		IRMA SHIPTON BURNS		8.9.65 112 ²⁵ P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
THE HOSPITAL FOR THE WOMEN OF MARYLAND				MARYLAND 27-15			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
				D. STREET ADDRESS (If rural, give location)			
				2410 BRAMBLETON ROAD			
5. SEX	6. RACE	7. <input checked="" type="checkbox"/> MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Min.	
F	W			9.2.1889	74		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOMEMAKER				PENNA.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
CLARENCE MALCOM SHANKWILER				LAURA JEANETTE SHIPTON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
				CHART			
18. 581.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
				(A) <u>Heart attack hemorrhage</u> DUE TO			
				(B) <u>Pulmonary hypertension</u> DUE TO			
				(C) <u>Liver cirrhosis</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
July 29, 1965		Paracentesis abd. for cytology		no			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from July 25, 1965 to Aug 9, 1965, that (I) (we) last saw the deceased alive on Aug 9, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Pacita D. Tan						Aug. 9, 1965	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
PACITA D. TAN				Women's Hosp., Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/12/1965		Loudon Park Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 12 1965		Robert E. Farkner		John A. Moran Inc.		3000 E. Baltimore St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8356		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8356	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) JOHN KENNEDY JR.			2. DATE AND HOUR OF DEATH AUGUST 10, 1965 3:00 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL BALTIMORE, Md.			A. STATE MD B. COUNTY 18-23		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) G.S. Corroffon Ave. Baltimore, Md.		
			D. STREET ADDRESS (If rural, give location) 6008 Henderson Avenue		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 6/24/1889	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Finisher - retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME NONE Martin Kennedy		14. MOTHER'S MAIDEN NAME NONE Mary Ann Kenney	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWI		16. SOCIAL SECURITY NO. 218-10-6187		17. INFORMANT HOSPITAL RECORD	
18. 153.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 7 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Pneumonia & Septicemia DUE TO			
		(B) Pneumonia, caecum & sec. Peritonitis DUE TO			
		(C) Carcinoma sigmoid colon obstructing Circulation, infarctional, liver			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 3 8-3-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruction		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from August 3 1965 to August 10 1965, that (I) (we) last saw the deceased alive on August 10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE R. Belbond		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-10-65	
23C. PHYSICIAN'S NAME (Type) ROSA RIO D. BELLO		M.D. UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/13/65		24C. NAME of CEMETERY or CREMATORY St. Joseph's Cemetery	
24D. LOCATION (City, town, or county) (State) Texas, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 12 1965		25B. NAME OF REGISTRAR Robert E. Jankewicz	
25C. FUNERAL DIRECTOR John A. Moran, Inc.		ADDRESS 3000 E. Balto. St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Under medical care; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 8357

BIRTH NO.

65 8357

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

AGNES JONES

2. DATE AND HOUR OF DEATH

August 9, 1965 7 35 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

900 Argyle Avenue Apt 3M

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (city)

Married

8. DATE OF BIRTH

3-24-1900

9. AGE (In years)

65

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Howard Co., Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Joseph Jones

14. MOTHER'S MAIDEN NAME

Margaret Brown

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-0784418

17. INFORMANT

ADDRESS

Colone Jones 900 Argyle Ave. Apt 3M

18. 420.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) Myocardial Infarction

INTERVAL BETWEEN
ONSET AND DEATH

36 hours

(B) Arteriosclerotic Cardiovascular
Disease

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8:00 AM 8.9.1965 to 7:35 PM 8.9.1965,
that (I) (we) last saw the deceased alive on 7:20 PM 8.9.1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did not) view the body after death.

23A. SIGNATURE

Nicholas J. Fortuin

M.D.

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

8.9.65

23C. PHYSICIAN'S
NAME (Type)

NICHOLAS J. FORTUIN

M.D.

23D. ADDRESS

The Johns Hopkins Hospital

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

8/12/65

Reshutes Mem. Ch. Baltimore

Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

AUG 12 1965

Robert E. Taylor

Ullington S. Phillips 1727 N. Monaca St.

NOV 19 1964

1964

BIRTH NO. **65 8358** BALTIMORE CITY HEALTH DEPARTMENT MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **65 8358**

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARY McDONALD

2. DATE AND HOUR PRONOUNCED DEAD

8/9/65 8:05 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1929 N. Collington Ave.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

NEVER MARRIED

8. DATE OF BIRTH

1-23-48

9. AGE (in years last birthday)

17

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

STUDENT

10B. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

S.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JAMES Mc DONALD

14. MOTHER'S MAIDEN NAME

ANNIE QUICK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

—

17. INFORMANT

JAMES Mc DONALD 1929 Collington Ave

ADDRESS

18.

260 X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Diabetes Mellitus

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/10/65

23A. BURIAL CREMATION, REMOVAL (Specify)

TRANSIT-BURIAL

23B. DATE

8-15-65

23C. NAME of CEMETERY or CREMATORY

NEW HIND BAPT. CEM

23D. LOCATION

Bennettsville, S.C.

24A. DATE REC'D BY HEALTH DEPT.

AUG 12 1965

24B. NAME OF REGISTRAR

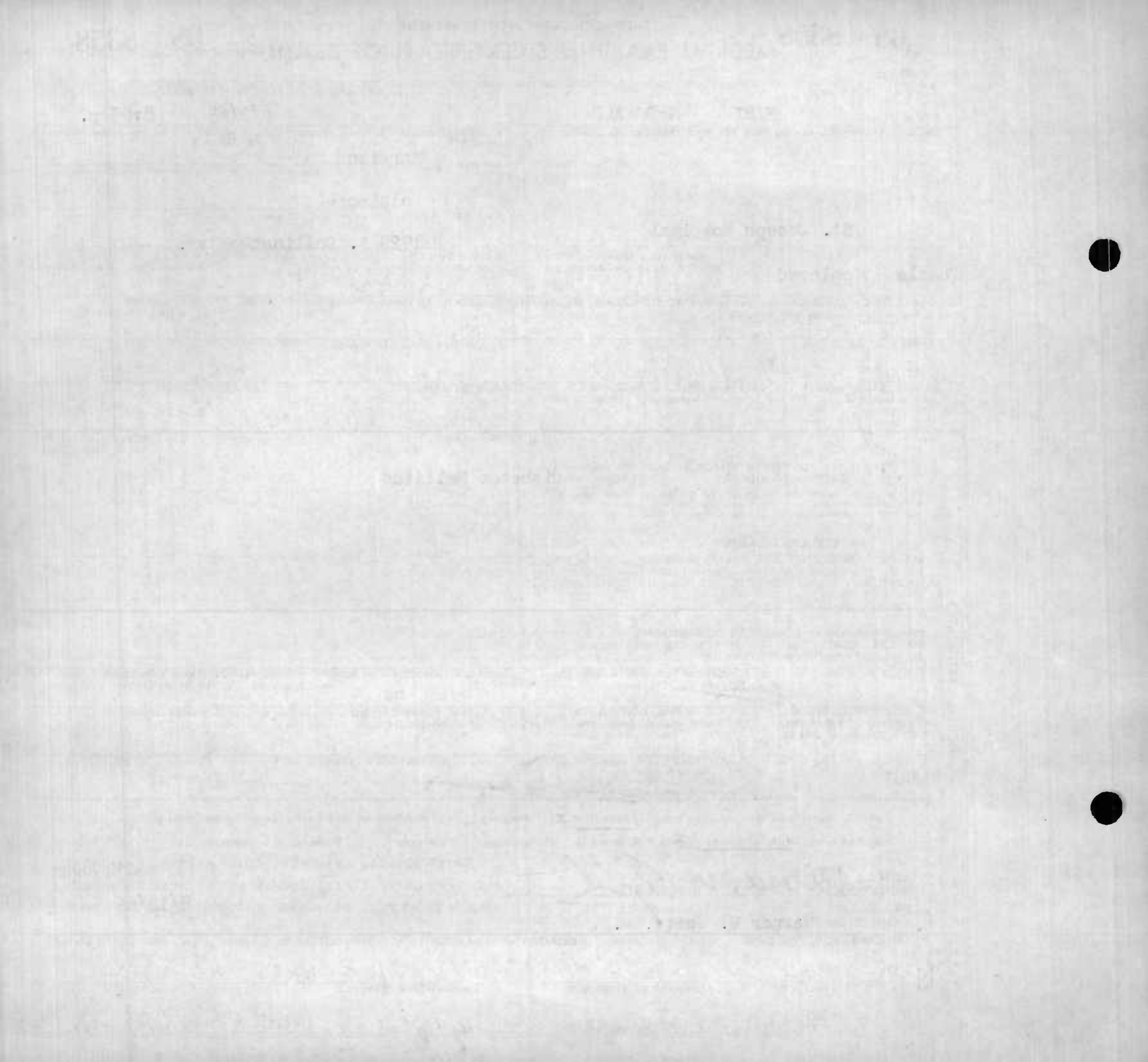
Robert E. Johnson

24C. FUNERAL DIRECTOR

Marshall W. Jones, JR.

ADDRESS

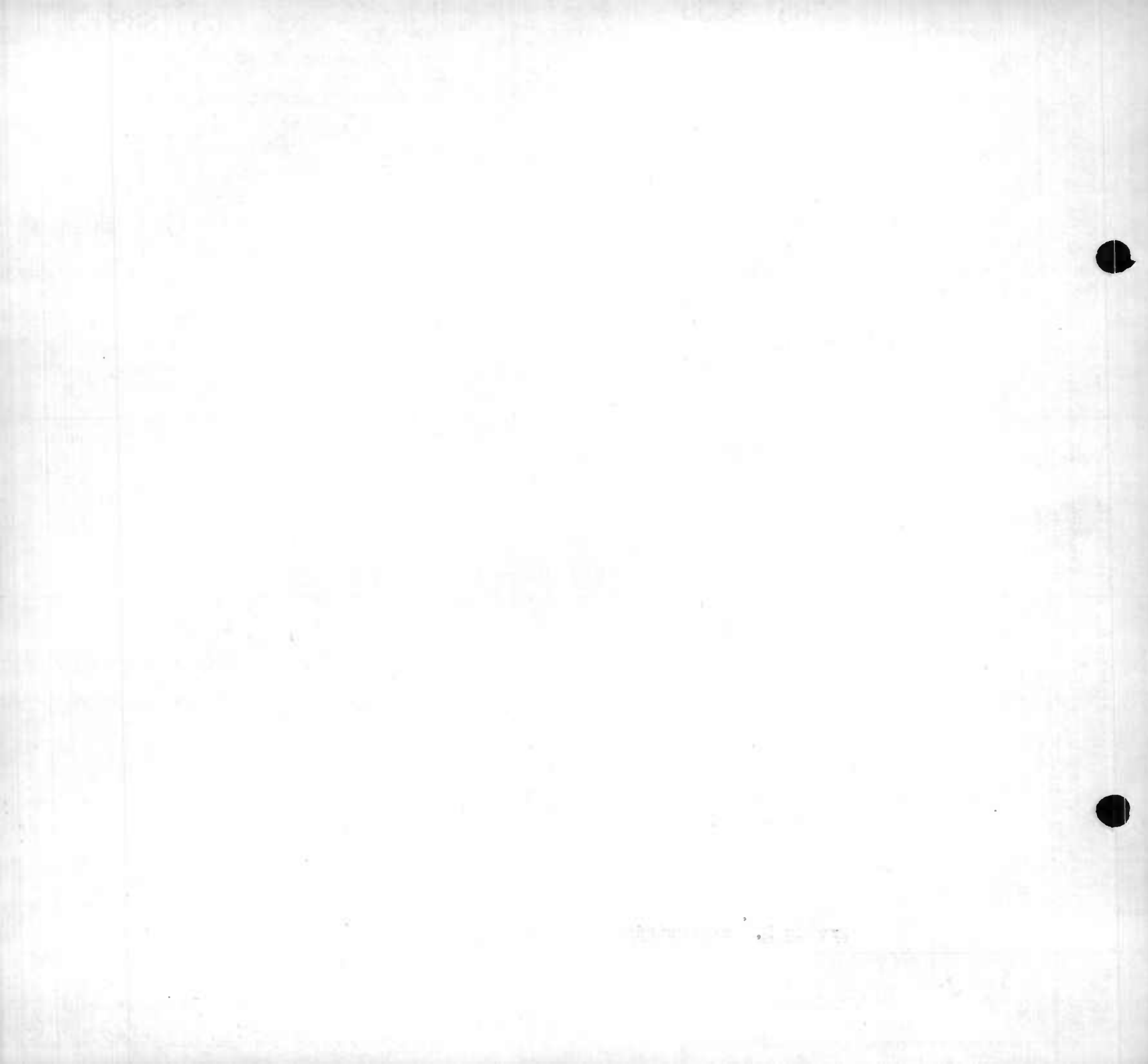
1735-37 HARTFORD AVE.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8359	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print)		HARRY EDWARD BREWER		2. DATE AND HOUR OF DEATH AUG. 10, 1965 1:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MONTABELLO STATE HOSP.		MARYLAND D.C.	
5. SEX M		6. RACE NEGRO		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 12/6/07	
GAS STATION ATTENDANT				9. AGE (In years last birthday) 57	
13. FATHER'S NAME NATHAN BREWER		14. MOTHER'S MAIDEN NAME IDA PARKER		11. BIRTHPLACE (State or foreign country) MARYLAND	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 29-16-0847		12. CITIZEN OF WHAT COUNTRY? U.S.	
17. INFORMANT PATIENT'S CHART		ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 72.3.1.1		CAUSE OF DEATH QUADRI PARALYSIS		INTERVAL BETWEEN ONSET AND DEATH +4 mo	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MAY 18 19 65 to AUG 10 19 65, that (I) (we) lost saw the deceased alive on AUG 9 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ruben C. Guerrero		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/10/65	
23C. PHYSICIAN'S NAME (Type) RUBEN C. GUERRERO		23D. ADDRESS Montebello State Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-13-65		24C. NAME of CEMETERY or CREMATORY Brewer Hill	
24D. LOCATION (City, town, or county) (State) Annapolis Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 12 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR William Keeseff, Anna Md.	



BIRTH NO. **65 8360** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **65 8360**

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)**MABLE JULIUS**

2. DATE AND HOUR PRONOUNCED DEAD

8/9/65 10:00 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)**Provident Hospital**4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE**Maryland**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1923 Druid Hill Ave.

5. SEX

female colored

6. RACE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)**Widowed**

8. DATE OF BIRTH

Dec. 27, 18999. AGE (In years
last birthday)**65**If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)**Domestic**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Bald. Md.12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William J. Sharp

14. MOTHER'S MAIDEN NAME

Hattie15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)**No**16. SOCIAL
SECURITY NO.

17. INFORMANT

Edna L. Oliver

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)**Arteriosclerotic cardiovascular disease**

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)**Werner U. Spitz, M.D.**CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/10/6523A. BURIAL CREMATION,
REMOVAL (Specify)**Removal**

23B. DATE

Aug. 13/65

23C. NAME of CEMETERY or CREMATORY

Forest Home

23D. LOCATION

(City, town, or county)

(State)

Boston Mass.

24A. DATE REC'D BY HEALTH DEPT.

AUG 12 1965

24B. NAME OF REGISTRAR

Robert E. Fadden

24C. FUNERAL DIRECTOR

Frank T. Elickson 1129 N. Calhoun

WALLLEY BOBGE

1890

WALLLEY BOBGE
1890

WALLLEY BOBGE

WALLLEY BOBGE

WALLLEY BOBGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8361				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 8361	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
Charles Henry Blume				8/10/65 11:03 AM		1103 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY			
Union Memorial Hospital				Maryland		Harford			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore		Baltimore	
				D. STREET ADDRESS (If rural, give location)		1222 Northview Rd		Green Rd.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
m	WHITE	Widowed	5/5/79	86					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
None Farmer		Accountant Retired		Baltimore Co Maryland		USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Frederick H Blume				Caroline Heil					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Unknown				216-46-8805		Mrs Grace M Blume		Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
433.11				Anteriosclerotic Cardio-vascular Disease					
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				Congestive heart Failure					
ANTECEDENT CAUSES				Benign Prostatic Hyperplasia with Urinary Retention					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Atrial Fibrillation					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0				NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 8/2/65 to 8/10/65, that (I) (we) last saw the deceased alive on 8/10/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Richard Rider Stephenson				8/10/65					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
Richard Rider Stephenson				Union Memorial Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		8/13/1965		Chestnut Grove		Jacksonville, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
AUG 12 1965		Robert E. Farley		Charles E. Kintz		Jarrettsville, Md.			

Report
on the
work of the
Committee

— *James M. Smith* —

1894-1895

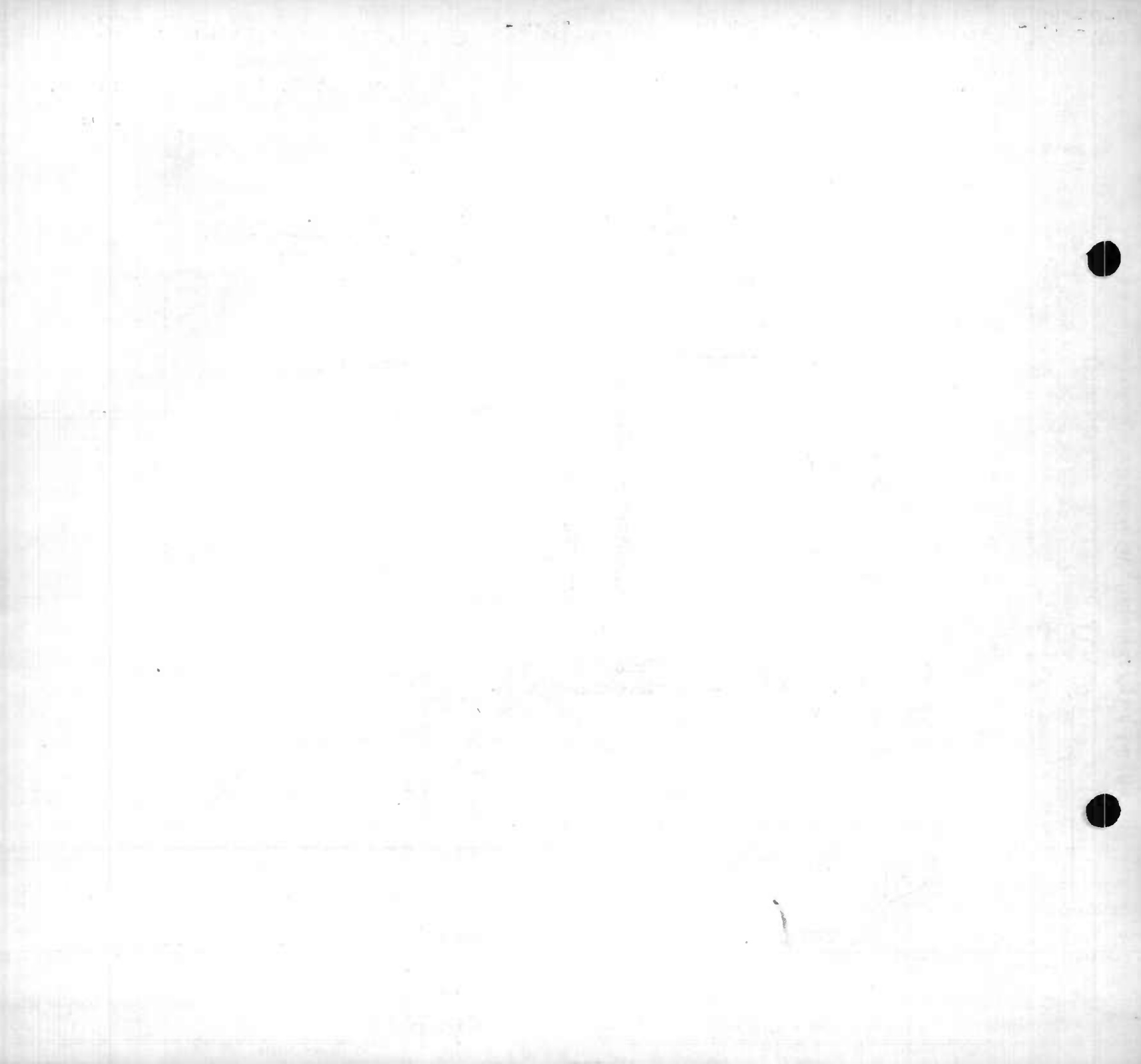
Received of the Treasurer of the
Board of Directors

31-08-49
CRF
K-32

TO BE APPROVED BY MEDICAL EXAMINER.
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

#13, Film 535 65 8362		HOSPITALITY HEALTH DEPARTMENT		Registered No. 65 8362	
BIRTH NO.		CERTIFICATE OF DEATH			
M.E. CASE NO. 9/13/79 kam		1. NAME OF DECEASED (Type or Print) Antonia Katsolias			
2. DATE AND HOUR OF DEATH August 9, 1965 6:25 P. M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland, #21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3806 Bank St.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 6-1891	9. AGE (In years lost birthday) 74	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greece	
12. CITIZEN OF WHAT COUNTRY? Greece		13. FATHER'S NAME Mihalis Panagoulakos Kyriako Panagos		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: BCH, 4940 Eastern Ave., #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia		19. CAUSE OF DEATH Pneumonia		20. INTERVAL BETWEEN ONSET AND DEATH 1 day	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		23. MEDICAL CERTIFICATION	
24. DATE OF OPERATION July 17, 1965		25. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture Right Hip-Intertrochanteric		26. AUTOPSY? (Yes or No) No	
27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3806 Bank St. 26-08	
30. TIME OF INJURY (APPROX.) 7 16 45 AM		31. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		32. HOW DID INJURY OCCUR? slipped & fell on floor	
33. I certify that (I) (this hospital) attended the deceased from July 16, 19 65 to August 9, 19 65, that (I) (we) last saw the deceased alive on August 9, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		34. SIGNATURE Thomas A. Otter		35. DATE SIGNED August 9, 1965	
36. PHYSICIAN'S NAME (Type) DR. THOMAS A. OTTER		37. ADDRESS M.D. 4940 Eastern Ave., Balto., Md., #21224		38. DATE SIGNED August 9, 1965	
39. BURIAL CREMATION, REMOVAL (Specify) Burial		40. DATE 8/13/65		41. NAME OF CEMETERY or CREMATORY St. Andrew Russian Orthodox Cemetery	
42. LOCATION (City, town, or county) Baltimore, Md.		43. DATE REC'D BY HEALTH DEPT. AUG 12 1965		44. NAME OF REGISTRAR Robert E. Taylor	
45. FUNERAL DIRECTOR Nicholas J. Matthews		46. ADDRESS 7 221 Eastern Ave, Baltimore 24, Md.		47. VS 150-REV. 1/1/65	



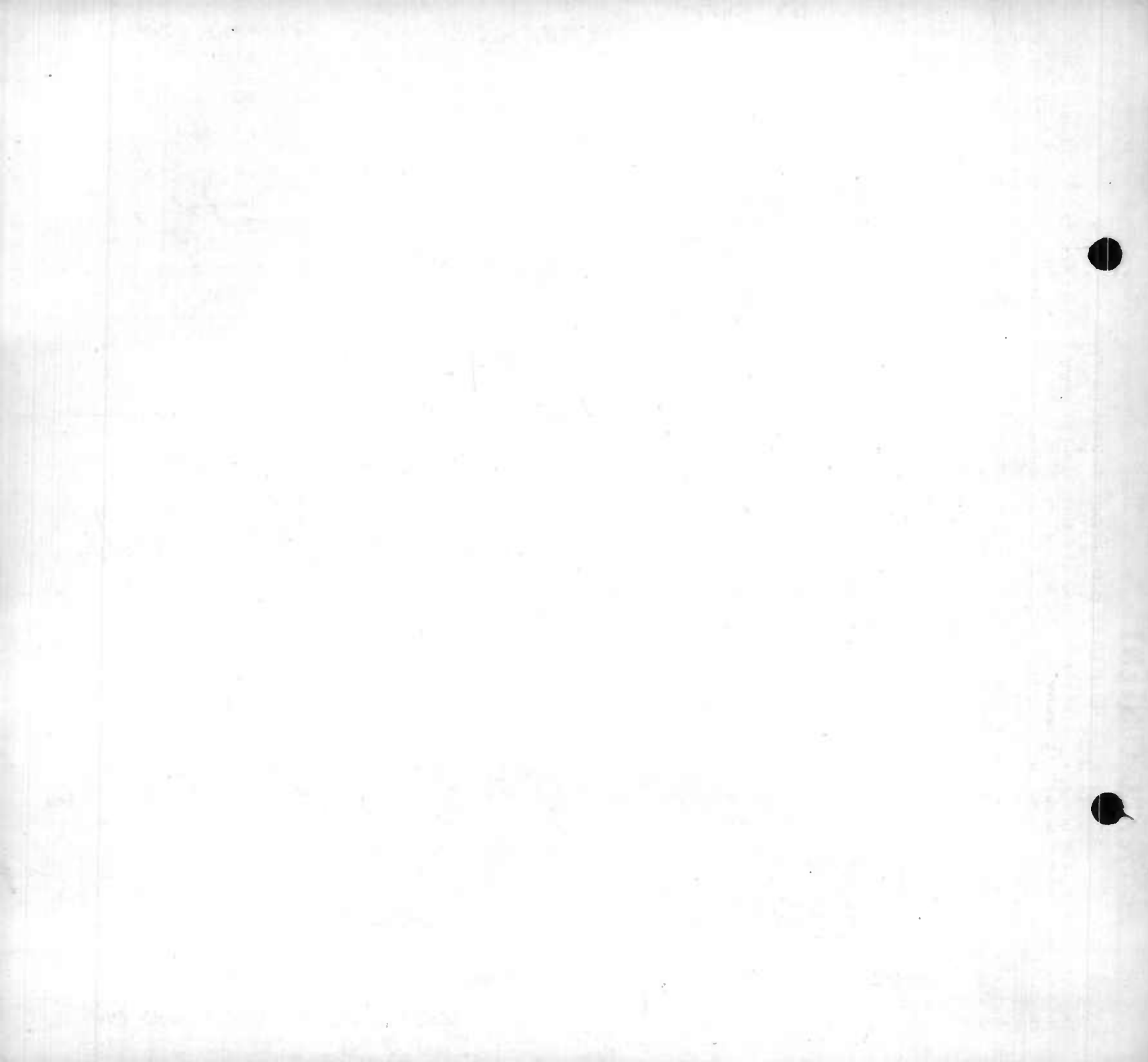
BIRTH NO. 65 8363		BALTIMORE CITY HEALTH DEPARTMENT		65 8363	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) JOSEPHINE HORCHER			2. DATE AND HOUR PRONOUNCED DEAD 8-8-65 10:20P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITAL - DOA			A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 533 S. Decker Avenue		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 3-22-04	9. AGE (In years last birthday) 61	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John L. Doyas			14. MOTHER'S MAIDEN NAME Elizabeth Marski		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. --	17. INFORMANT ADDRESS Mrs. Mary S. Sanders 515 S. Decker Ave., Baltimore 24		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR?			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) PETER W. RIECKERT, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8-9-65	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 8-12-65	23C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery		23D. LOCATION (City, town, or county) (State) Baltimore, Maryland
24A. DATE REC'D BY HEALTH DEPT. AUG 12 1965		24B. NAME OF REGISTRAR Robert E. Farley, M.D.		24C. FUNERAL DIRECTOR ADDRESS Nicholas T. Matthews 3021 Eastern Ave., Baltimore 24	

VALLEY FORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8364	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) William Harrison		2. DATE AND HOUR OF DEATH 8-8 1965 1:30 p M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland B. COUNTY Baptist Home	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) George Washington Carver Nursing Home		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location) 16-06	
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH ?	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME SARAH ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Char+ #	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Arterio vascular accident DUE TO (B) Hypertensive intracerebral DUE TO cardio vascular disease (C) muscle		INTERVAL BETWEEN ONSET AND DEATH 2/3/64	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 2/3 1964 to 8/8 1965 that (I) (we) last saw the deceased alive on 8/8 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE J.N. Mac Murthy		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Aug 8/65	
23C. PHYSICIAN'S NAME (Type) J.N. MAC MURTHY		M.D.		23D. ADDRESS 500 E Madison St	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 8/13/65		24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) A A County Md		25A. DATE REC'D BY HEALTH DEPT. AUG 12 1965		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave			



BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 8365 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 8365

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FRANK BROWN

2. DATE AND HOUR PRONOUNCED DEAD

8/7/65 3:40 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

512 Bloom St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

512 Bloom St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

?

8. DATE OF BIRTH

9. AGE (In years
last birthday)

85

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
218-18-1286

17. INFORMANT

ADDRESS

Mr John Martin 720 N Mount St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Manual strangulation
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

512 Bloom St.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8 7 65 ?

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

apparently strangled

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Warner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/8/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/12/65

23C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cemetery

23D. LOCATION

(City, town, or county)

A A County Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 12 1965

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

ADDRESS

WALLLEY FORTGE

ALL CONTENT

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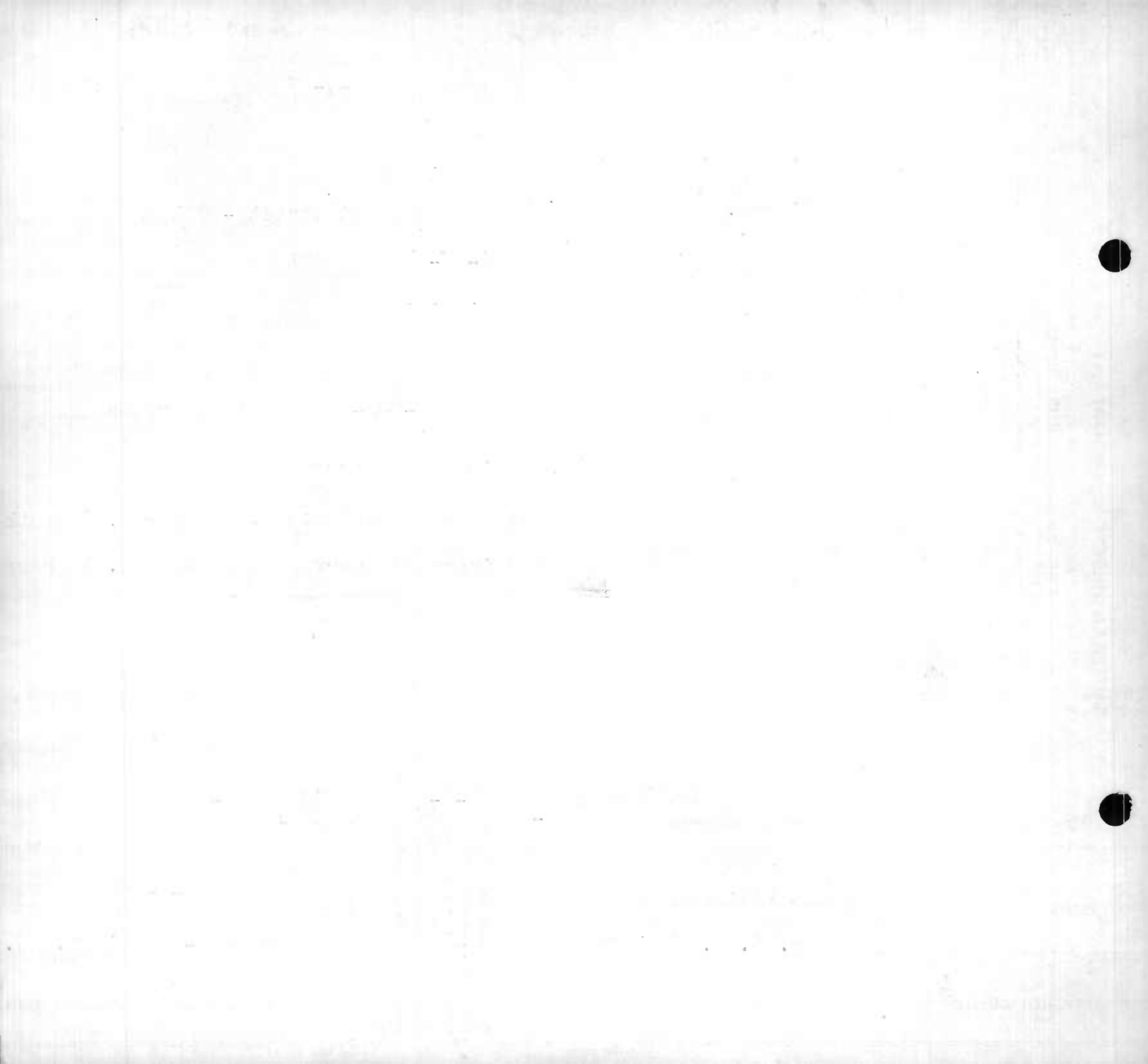
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 65 8366	
BIRTH NO. 65 8366		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Cora Hall		2. DATE AND HOUR OF DEATH 8-9-65 12:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		A. STATE Maryland B. COUNTY 18-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1140 Forrest Street - #21202			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 6-15-94	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS-BCH-4940 Eastern Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory Arrest		CAUSE OF DEATH (A) Respiratory Arrest DUE TO (B) Pulmonary Metastasis DUE TO (C) Carcinoma of Ovary		INTERVAL BETWEEN ONSET AND DEATH approx. 8 months approx. 3 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-6-1965 to 8-9-1965 , that (I) (we) last saw the deceased alive on 8-9-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. D. Kreider		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-9-65	
23C. PHYSICIAN'S NAME (Type) Dr. S. D. Kreider		23D. ADDRESS #21224 BCH-4940 Eastern Avenue - Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-13-65		24C. NAME OF CEMETERY or CREMATORY Salisbury N.C.	
24D. LOCATION (City, town, or county) (State) Salisbury N.C.		25A. DATE REC'D BY HEALTH DEPT. AUG. 13 1965			
25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR William Wright		ADDRESS 2700 Edmondson Ave - 23	



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D-120

65 8367

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 8367

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES

DAVIS

2. DATE AND HOUR PRONOUNCED DEAD

August 11, 1965

9:45 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Bon Secour Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1911 Lauretta Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

May 18 - 1944

9. AGE (In years
last birthday)

21

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Subemployee

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Washington, D.C.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

James Davis

14. MOTHER'S MAIDEN NAME

Beenie Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, No or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Beenie Davis

ADDRESS

Same

18.

E 813.3

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Craniocerebral Injury.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Payson and Mulberry Streets

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

8

11

'65

P

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Bicyclist struck by truck.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/12/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-16-1965

23C. NAME OF CEMETERY or CREMATORY

Mt Calvary Cmt

23D. LOCATION (City, town, or county)

Brooklyn MD

(State)

24A. DATE REC'D BY HEALTH DEPT.

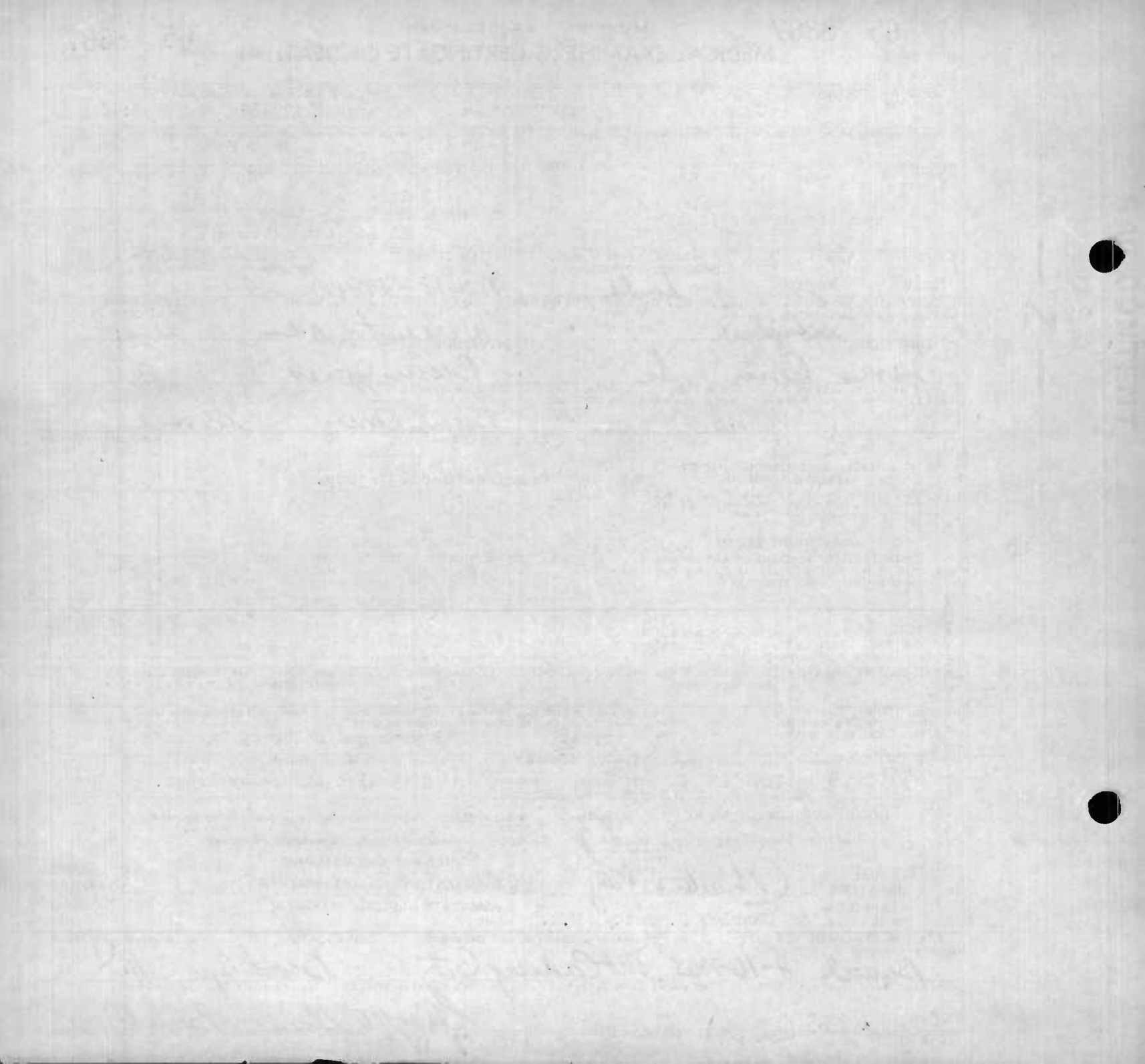
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

AUG 13 1965

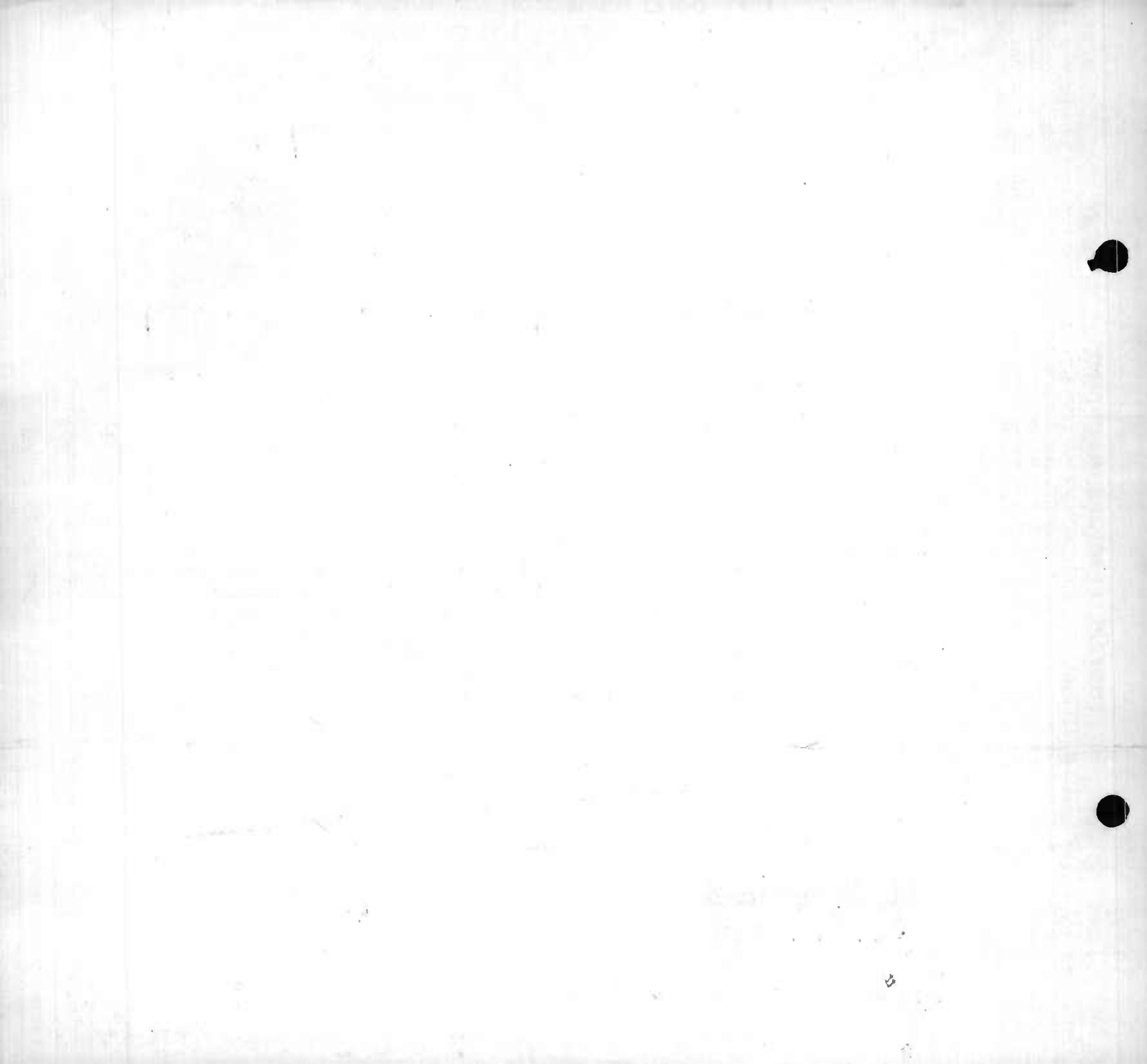
VS 151-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>65</u> <u>8368</u>	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Vernon Govham</u>		2. DATE AND HOUR OF DEATH <u>8/12/65 12:40 AM</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Johns Hopkins Hospital</u>				A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>33 - N. Eden St</u>			
5. SEX <u>Male</u>	6. RACE <u>colored</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>		8. DATE OF BIRTH <u>3-18-31</u>	9. AGE (In years last birthday) <u>34</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Govham</u>				14. MOTHER'S MAIDEN NAME <u>Lucille Tillery</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Alphonse Govham</u>		ADDRESS	
18. <u>446X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Nephrosclerosis</u> DUE TO (B) <u>Hypertension</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>25 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>NONE</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>7/2</u> 19 <u>65</u> to <u>8/12</u> 19 <u>65</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>8/2</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>W.H. Spencer III</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/12/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. W.H. SPENCER</u>				23D. ADDRESS <u>Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-16-1965</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cmt</u>		24D. LOCATION (City, town, or county) (State) <u>Brooklyn MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 13 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>Chas E. Wicks 1000 Beantley</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8369	
BIRTH NO. 65 8369		CERTIFICATE OF DEATH			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) CHARLOTTE DECOURSEY		2. DATE AND HOUR OF DEATH 8/18/65 11:00 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1812 Duval Hill Dr.			
5. SEX F	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH Aug 16 1901	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAID		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Alexander Howard		14. MOTHER'S MAIDEN NAME Louisa Green			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-32-4559		17. INFORMANT AMB #11 Shingo Howard	
18. 330X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Subarachnoid hemorrhage ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Ruptured aneurysm		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 10 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 10000		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Union Memorial Hospital	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work <input type="checkbox"/> AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from July 30 1965 to August 9 1965 , that (we) last saw the deceased alive on Aug. 9 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.					
23A. SIGNATURE Walter D. Boone		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/19/65	
23C. PHYSICIAN'S NAME (Type) WALTER J. BOONE, Walter D. Boone		23D. ADDRESS UNION MEMORIAL HOSPITAL Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/16/65	24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 13 1965		25B. NAME OF REGISTRAR Robert E. Fagan		25C. FUNERAL DIRECTOR William E. March	
				ADDRESS 728 E. North Ave.	

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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
65 8370						65 8370	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD			
JOHN David NORRIS, Sr.				8-11-65		1:25 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Maryland			
UNIVERSITY HOSPITAL				B. COUNTY Harford			
				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
				Bel Air			
				D. STREET ADDRESS (If rural, give location)			
				111 S. Reed Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
Male	White	Married	June 10, 1915	50			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Automobile Dealer		Used Car Lot-Owner		Baltimore, Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
David Calvin Norris				Carrie L. Ely			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT (Wife) 879-8915		ADDRESS	
No		212-18-8788		Mrs. Evelyn S. Norris		111 S. Reed St/ Bel Air, Md. 21014	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) Gunshot wound of head DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C)			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				Yes		Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
		Home		111 S. Reed Street, Bel Air, Md.			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
8 9 '65 11:30 AM		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Shot self in head			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
RUDIGER BREITENECKER, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		8-11-65	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Burial		August 13, 1965		Bel Air Mem. Gardens		Bel Air, Harf. Co., Md. 21014	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS	
AUG 13 1965		Robert E. Farley, M.D.		Joseph William Foster		W. Broadway & Williams Bel Air, Maryland 21014	

David L. Davis

1910

June 10, 1912

David L. Davis

U.S.A.

Bellevue, Maryland

Head of Laboratory

Automobile Dealer

David L. Davis

David L. Davis

(Miss) 1912-1913

111 S. Reed St.

212-1-2388 Mrs. Evelyn S. Davis

Bel Air, Md. 21034

August 12, 1904 Bel Air, Md. Davidson

David

W. Broadway & Alliance
Bel Air, Maryland 21034

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
65 8371						65 8371	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD			
NANCY LEE HUMPHREY				8/9/65 12:40 p M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Maryland B. COUNTY Baltimore			
St. Agnes Hospital				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7 53-00			
D. STREET ADDRESS (If rural, give location) Box 184 Dogwood Rd.							
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (in years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
female	white	MARRIED	9-19-1937	27			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE		AT HOME		Balto Co. Md.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
CHARLES GRILL				MILDRED HARTONG			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		213-36-8541		MARVIN HUMPHREY		Dogwood Rd. Balto 7. Md.	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) Generalized amniotic fluid embolism DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C)			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				yes		yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				ASSOCIATE MEDICAL EXAMINER		8/10/65	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
BURIAL		8-13-65		Good Shepherd		Ellicott City Md.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS	
AUG 13 1965		Robert E. Taylor, Jr.		F. G. Higginbotham		Ellicott City Md.	

8/20/65 - Full term - still born delivered by
Caesarean section - information
from Med. Ex. office via phone
gc

VALLEY FORCE

IN CONTENT

U.S.A.

1965

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1965

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1965

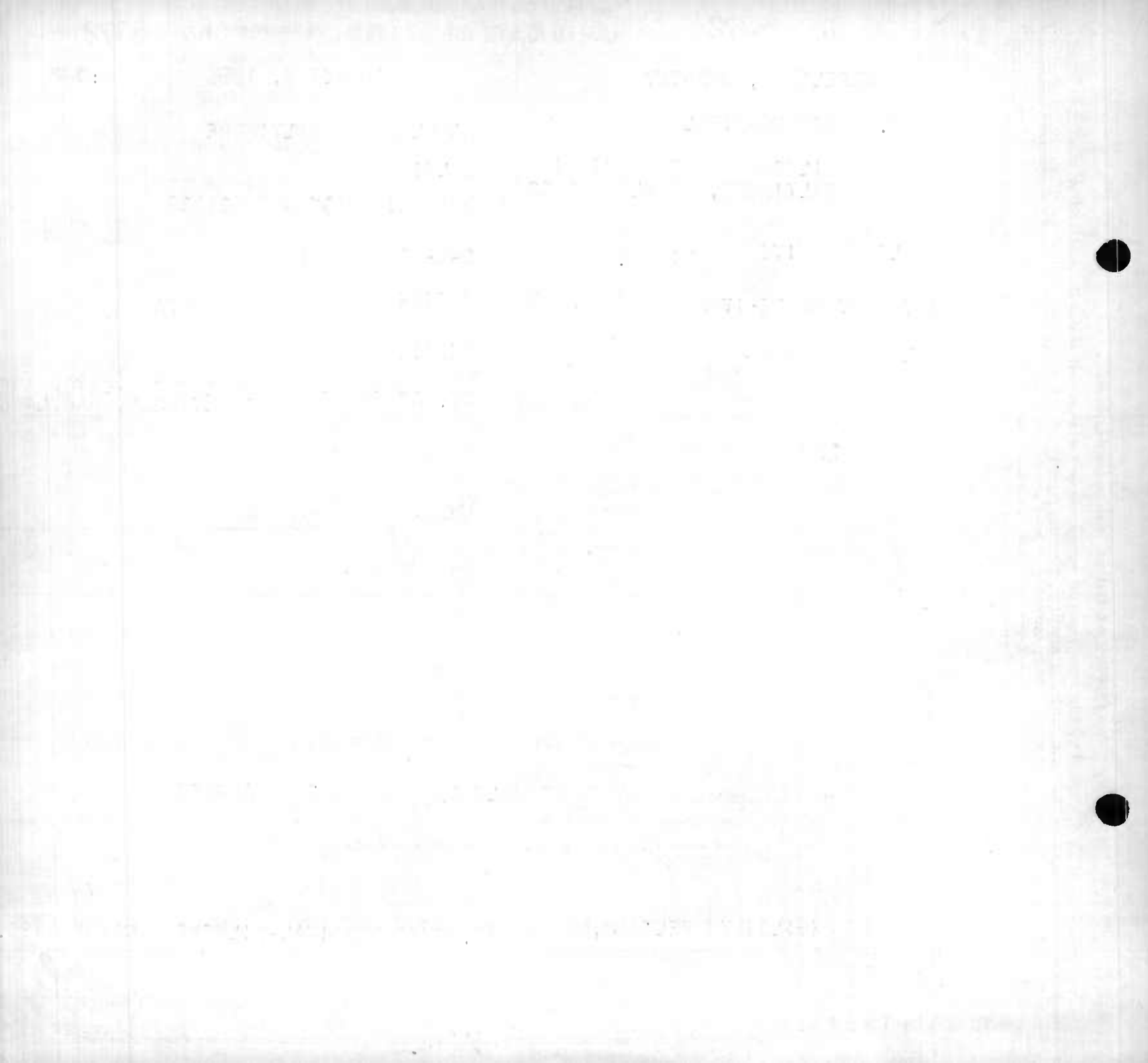
1965

1965

FUNERAL DIRECTOR: IMPORTANT

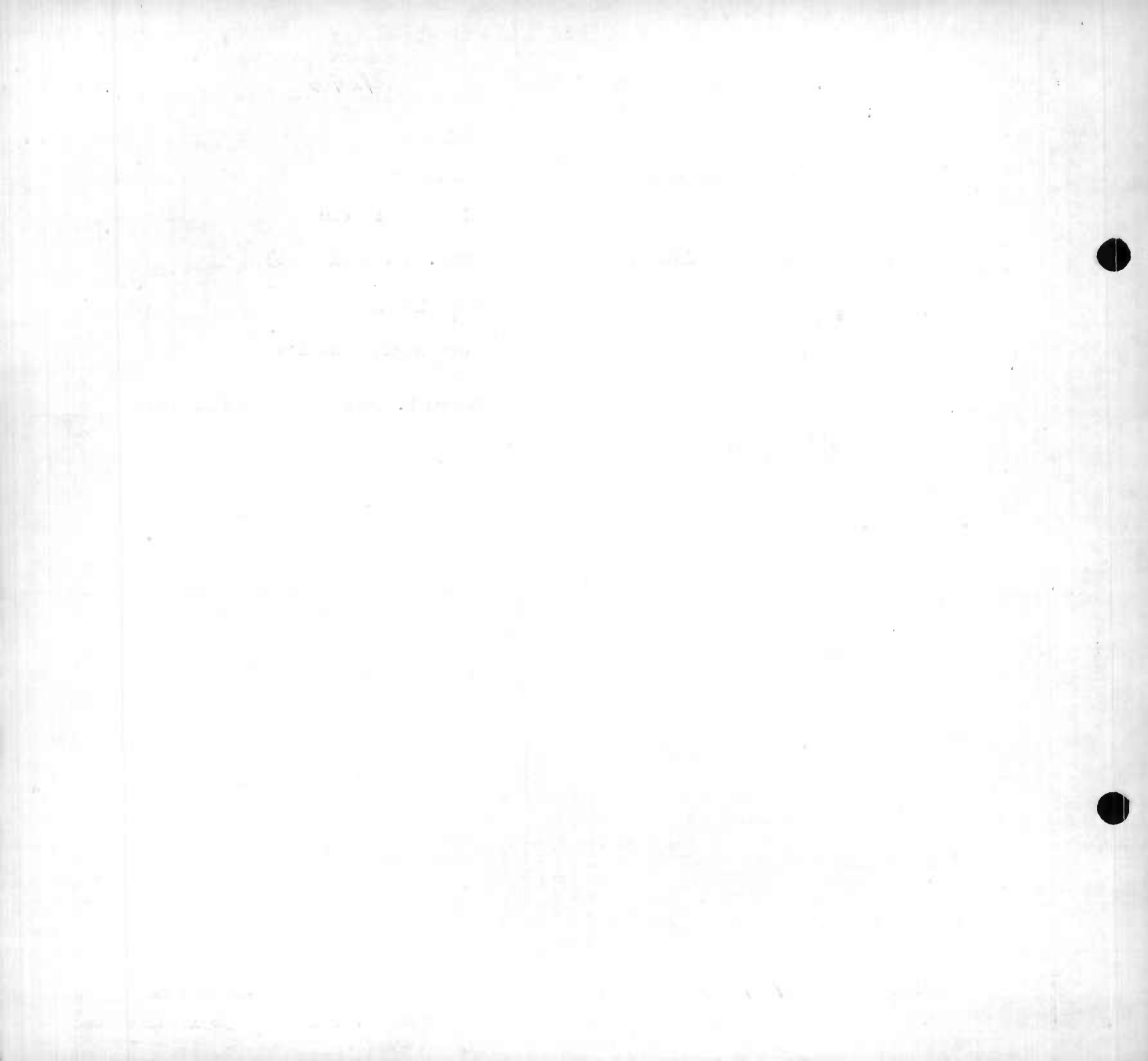
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8372		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8372	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) VASELAROS, DOROTHY		2. DATE AND HOUR OF DEATH AUGUST 8, 1965 9:00P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND ST. AGNES HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION If not in hospital or institution, give street address or location WILKENS & CATON AVENUES BALTIMORE, MARYLAND 21229		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4936 LINDSAY ROAD 21229			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 2-2-12	9. AGE (In years last birthday) 53	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESTURANT PROPERITOR		10B. KIND OF BUSINESS OR INDUSTRY RESTURANT		11. BIRTHPLACE (State or foreign country) GREECE	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME PAUL POLIS			
14. MOTHER'S MAIDEN NAME BESSIE		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 220-38-9436		17. INFORMANT ST. AGNES RECORDS- BALTIMORE, MARYLAND			
18. 581.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO Hepatic Insuff (B) DUE TO Biliary Cirrhosis (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JULY 15 1965 to AUGUST 8 1965, that (X) (we) last saw the deceased alive on AUGUST 8 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE Edilberto N. Beltran		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-9-65	
23C. PHYSICIAN'S NAME (Type) EDILBERTO BELTRAN, MD		23D. ADDRESS ST. AGNES HOSPITAL-WILKENS & CATON AVES.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-12-65		24C. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cem.	
24D. LOCATION (City, town, or county) (State) Woodlawn Md		25A. DATE REC'D BY HEALTH DEPT. AUG 13 1965			
25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR John J. Farkner			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

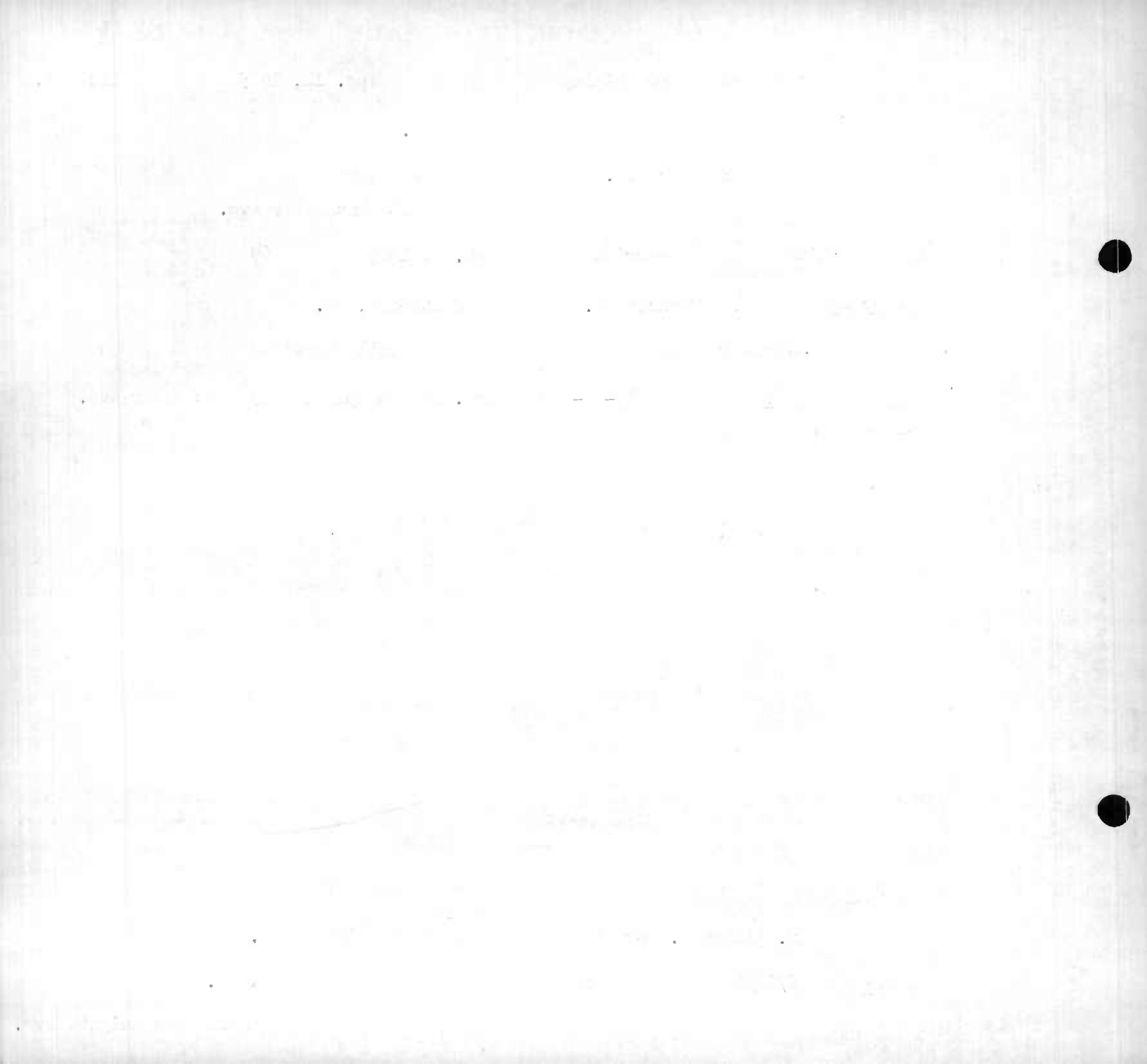
BIRTH NO. 65 8373				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8373	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mrs. Anna Callan Tunney				2. DATE AND HOUR OF DEATH 8/10/65 4:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 27-15 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4250 Falls Road			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Sept. 18, 1881	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Callan			14. MOTHER'S MAIDEN NAME Mary Regina McGuire				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT Edward C. Tunney			ADDRESS 4250 Falls Road
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HYPERTENSIVE CARDIOVASCULAR DS.				(B) DUE TO		YEARS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II				(C)			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 1st 19 65 to AUGUST 8 19 65 , that (I) (we) last saw the deceased alive on AUGUST 8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE L. J. ELIAS				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) L. J. ELIAS		23D. ADDRESS 1701 MERIDEN DR. BALTIMORE, MD.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/13/65		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 13 1965		25B. NAME of REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Burgee Funeral Home			
				ADDRESS 3631 Falls Road			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8374	
BIRTH NO. 65 8374		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Herbert Oliver Shipley		2. DATE AND HOUR OF DEATH Aug. 12, 1965 11:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 3613 Manchester Ave.		A. STATE Md. B. COUNTY 27-18			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3613 Manchester Ave.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Oct. 7, 1895	9. AGE (In years lost birthday) 69	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY Transit Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Joshua Shipley			
14. MOTHER'S MAIDEN NAME Emily Warfield		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W #1			
16. SOCIAL SECURITY NO. 213-05-9199		17. INFORMANT ADDRESS Mrs. Emma Shipley, 3613 Manchester Ave.			
18. 3 27-11		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) Cerebral occlusion DUE TO		August 12, 1965	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Pulmonary Emphysema DUE TO		5 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) Arteriosclerosis General Interstital fibrosis lung		5 yrs. 5 yrs	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from April 3 1965 to August 12 1965, that (I) (we) last saw the deceased alive on August 12 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (didn't) view the body after death.					
23A. SIGNATURE Milton E. Lowman				23B. DATE SIGNED 8-12-65	
23C. PHYSICIAN'S NAME (Typed) Dr. Milton E. Lowman				23D. ADDRESS 4843 Park Heights Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/65		24C. NAME OF CEMETERY OR CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 13 1965			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Robert E. Taylor		ADDRESS 4611 Park Heights Ave.	



BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 8375 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 8375

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN FABISZAK

2. DATE AND HOUR PRONOUNCED DEAD

8/10/65 11:30 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

813 S. Lakewood Ave.

813 S. Lakewood Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

SHIPPING CLERK

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

FABISZAK

14. MOTHER'S MAIDEN NAME

ELIZABETH PRZYBILSKI

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
(If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/10/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

8-13-65

23C. NAME OF CEMETERY or CREMATORY

MT. CARMEL

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE

24A. DATE REC'D BY HEALTH DEPT.

AUG 13 1965

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

F. OZARZEWSKI-1930 EASTERN AVE-
21231

ADDRESS

WALTER M. COFFIN

PROCLAIMANT

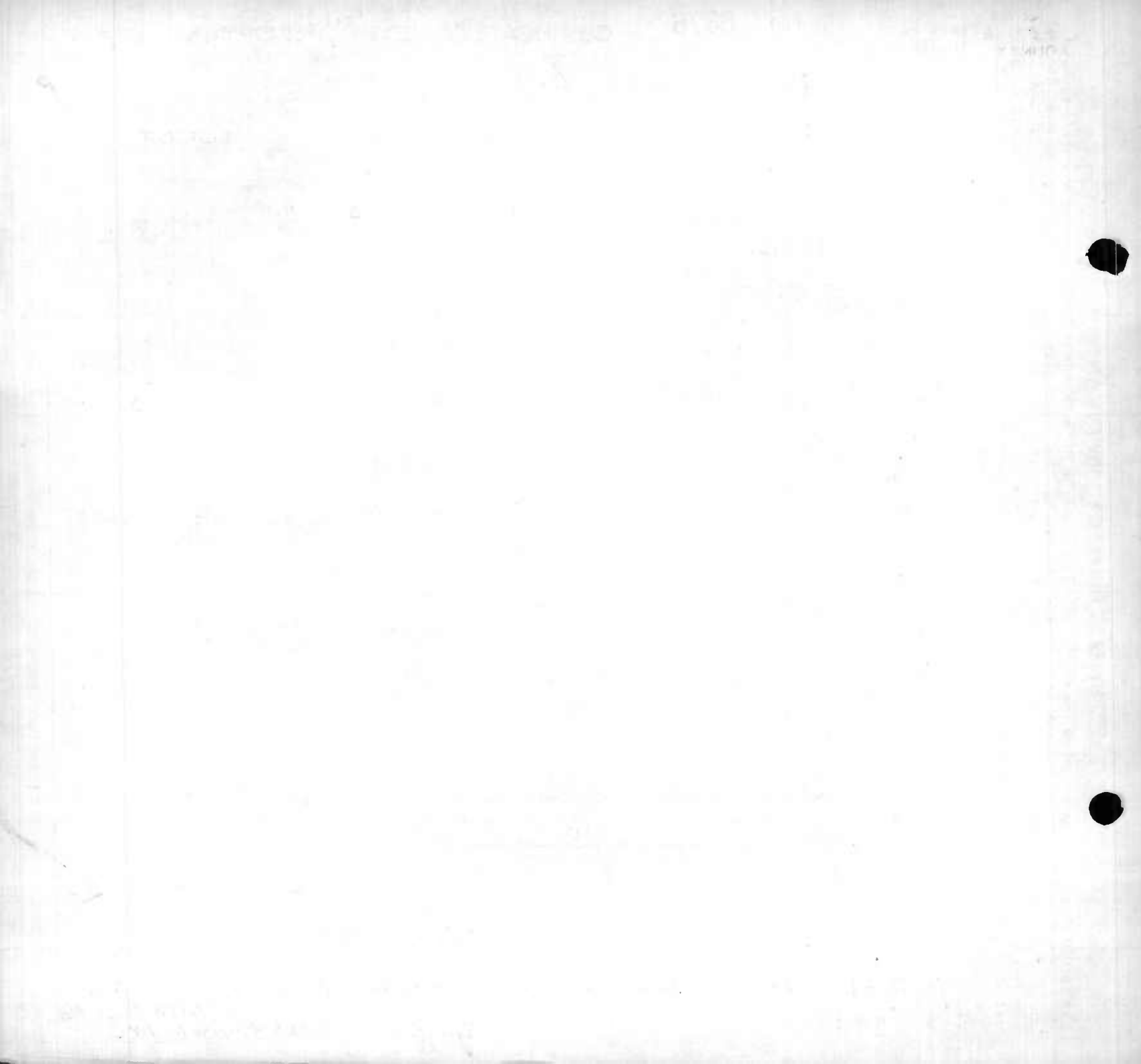
1904



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 8376		BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8376			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) VIRDEN, CHARLES L.				2. DATE AND HOUR OF DEATH 8/8/65 4:45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSPITAL						A. STATE MARYLAND B. COUNTY Balt			
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 63-00			
						D. STREET ADDRESS (If rural, give location) 35 CEDAR AVE.			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 11-11-98	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAIRMAN OF BOARD R. AVERY CO.				10B. KIND OF BUSINESS OR INDUSTRY WELDING WIRE		11. BIRTHPLACE (State or foreign country) PENN.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES O. VIRDEN				14. MOTHER'S MAIDEN NAME HEIM					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES NAVY WW I.				16. SOCIAL SECURITY NO.		17. INFORMANT MRS. VIRDEN		ADDRESS 35 CEDAR AVE.	
18. 162.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) PNEUMONIA DUE TO				INTERVAL BETWEEN ONSET AND DEATH 1 WEEK	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) BRONCHOGENIC CARCINOMA DUE TO				9 MONS.	
				(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCVD & MYOCARDIAL INFARCTION (12/63)									
19A. DATE OF OPERATION DEC. 3, 1964		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA of LUNG.		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/5 19 65 to 8/8 19 65 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/8 19 65 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death.									
23A. SIGNATURE J. A. Christmas M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED 8-8-65			
23C. PHYSICIAN'S NAME (Type) SINAI HOSP.						23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-11-65		24C. NAME OF CEMETERY or CREMATORY BULANEY VALLEY MEMORIAL		24D. LOCATION (City, town, or county) (State) TOWSON Md			
25A. DATE REC'D BY HEALTH DEPT. AUG 13 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR WM. SOPK-BROOKS		ADDRESS 1050 YORK RD.			



1
5-100

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

65 8377

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 8377

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

~~ALCAEUS~~
~~LACAEUS~~

H. SCHOFF

2. DATE AND HOUR PRONOUNCED DEAD

8/10/65 8:15 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

314 S. Highland Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

314 S. Highland Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

11/14/94

9. AGE (In years
lost birthday)

70

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Balto. Transit Co. (Retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.Y.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

213-10-1361

17. INFORMANT

ADDRESS

Mrs. Robinson 289 Bellow Ct.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐

NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/10/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/13/65

23C. NAME OF CEMETERY or CREMATORY

Balto. National

23D. LOCATION

(City, town, or county) (State)

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 13 1965

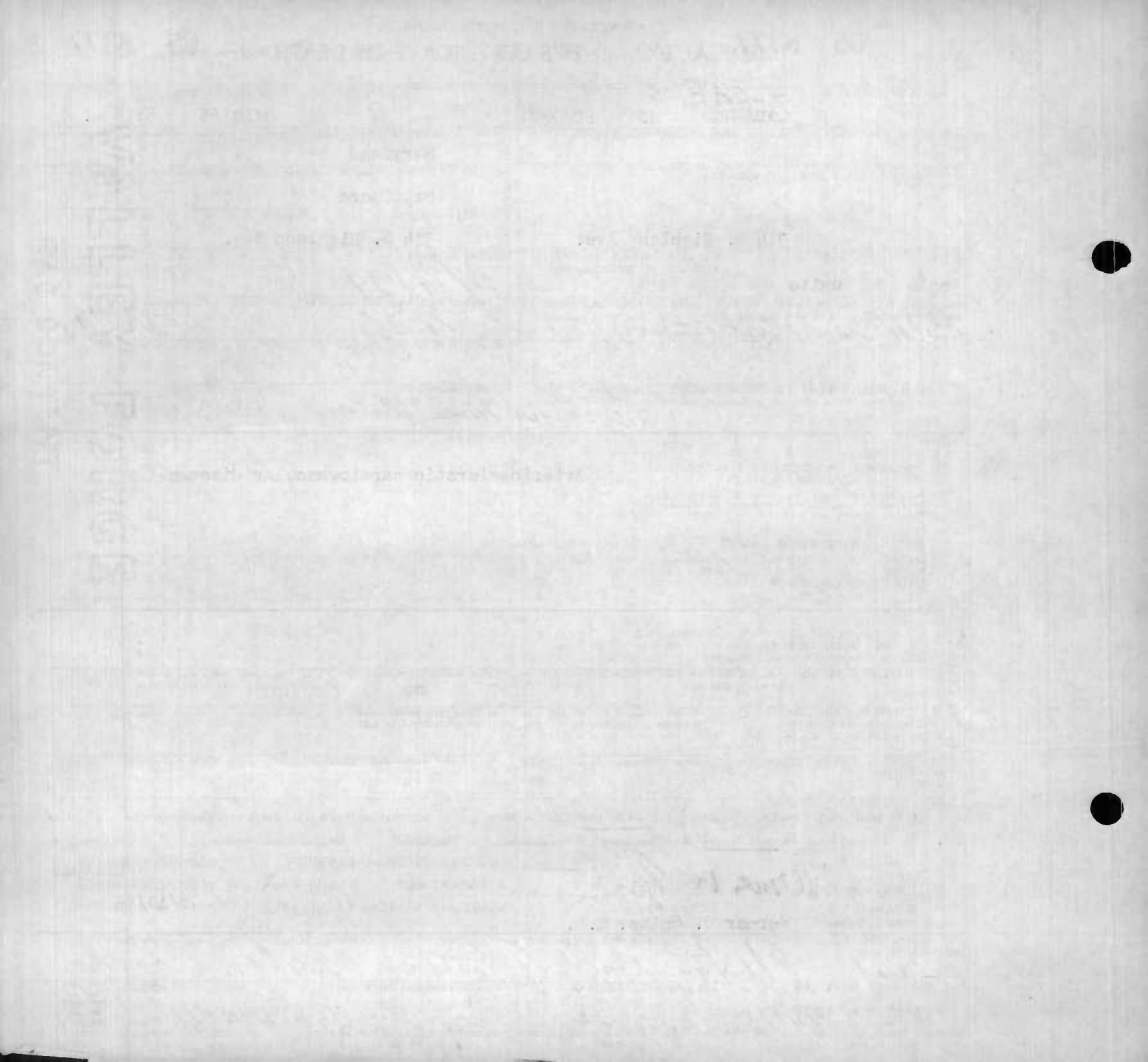
24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

Connelly 300 Mace Ave. Balto.

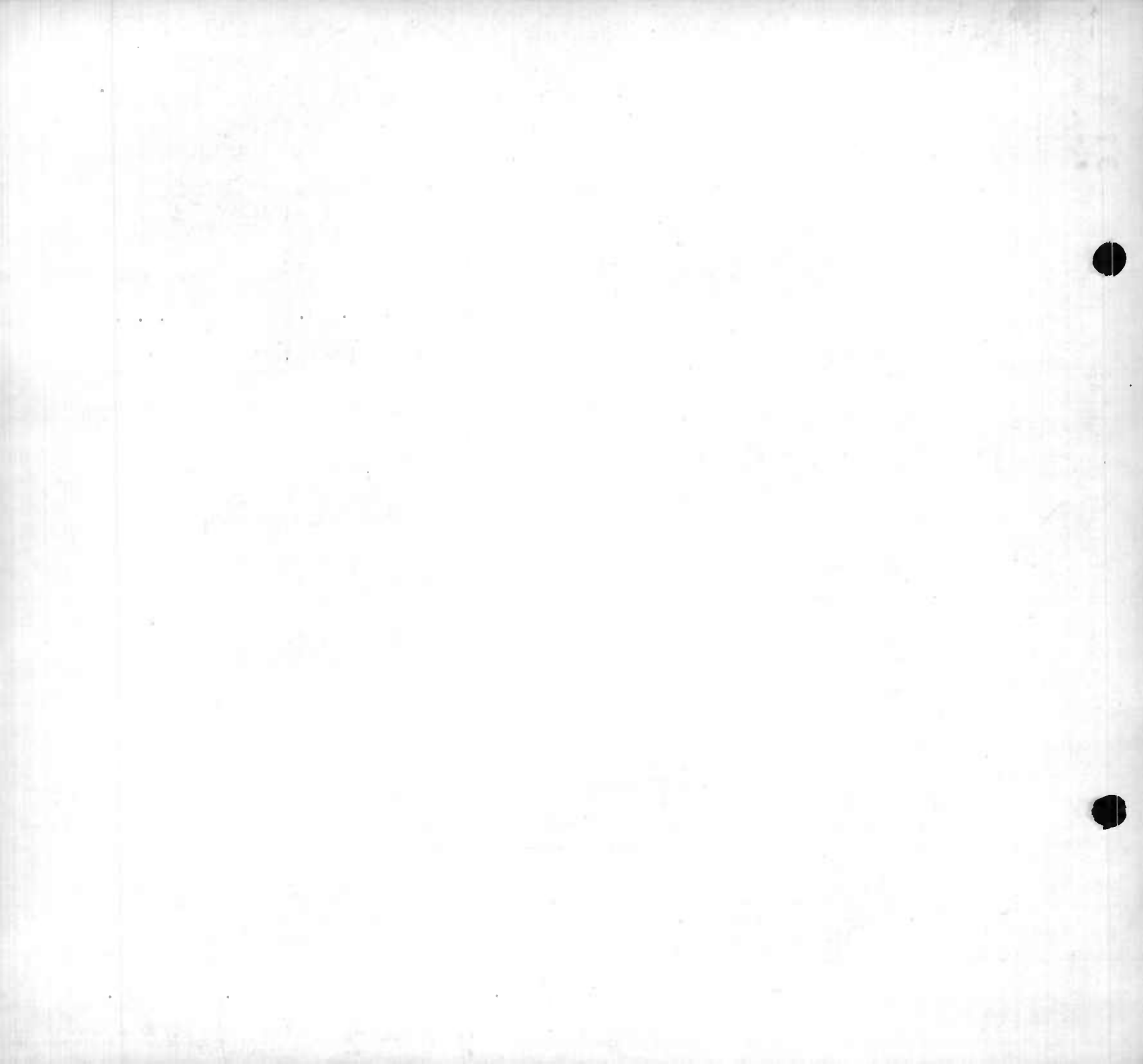
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		65 8378		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8378	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HENRY MOHR				2. DATE AND HOUR OF DEATH 8-7-65 11.18 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 9525 PULASKI HIGHWAY #6			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-16-84	9. AGE (In years lost birthday) 81	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10B. KIND OF BUSINESS OR INDUSTRY B & O Rail Road		11. BIRTHPLACE (State or foreign country) Baltimore, Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRED MOHR			14. MOTHER'S MAIDEN NAME AMELIA NAIMEISTER				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-09-7429		17. INFORMANT ADDRESS Mrs Elizabeth Mohr 9525 Pulaskia Hgwa			
18. 450.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) VENOUS STASIS → THROMBOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Mild congestive heart failure arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 3-8-4-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Benign Prostatic Hypertrophy		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-26 19 65 to 8-7 19 65 , that (I) (we) last saw the deceased alive on 8-7- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE John C Wade M.D.				23B. DATE SIGNED 8-7-65			
23C. PHYSICIAN'S NAME (Type) DR J. S. Haines		23D. ADDRESS JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-11-1965		24C. NAME of CEMETERY or CREMATORY Zion United Luth. Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 13 1965		25B. NAME OF REGISTRAR Robert S. Feltner		25C. FUNERAL DIRECTOR ADDRESS Longshore Funeral Home 7401 Belair Road			



BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 65 8379		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 85 8379	
M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) CHARLES W. NOLL		2. DATE AND HOUR PRONOUNCED DEAD 8/9/65 9:50 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital 8/23/65		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY A. A. Co. C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pasadena 52-00 D. STREET ADDRESS (If rural, give location) Rte. 6 Box 526	
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH July 28, 1910
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10B. KIND OF BUSINESS OR INDUSTRY Baltimore City	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
13. FATHER'S NAME 1601601 CHARLES NOLL		14. MOTHER'S MAIDEN NAME Theresa Kummell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-03-1112	17. INFORMANT ADDRESS Mrs. Gladys May Noll - same
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Diabetes Mellitus OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) no
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) Werner U. Spitz, M.D.		DATE SIGNED 8/10/65	
23A. BURIAL CREMATION, REMOVAL (Specify) burial	23B. DATE Aug. 12, 1965	23C. NAME of CEMETERY or CREMATORY Glen Haven Memorial Cem.	23D. LOCATION (City, town, or county) (State) Anne Arundel Co., Maryland
24A. DATE REC'D BY HEALTH DEPT. AUG 13 1965		24B. NAME OF REGISTRAR Robert E. Johnson	24C. FUNERAL DIRECTOR ADDRESS George J. Gonce, 4001 Ritchie Hwy. Baltimore 25, Md.

letter from funeral director. 8/23/65

c.Bowens letter in pending file.

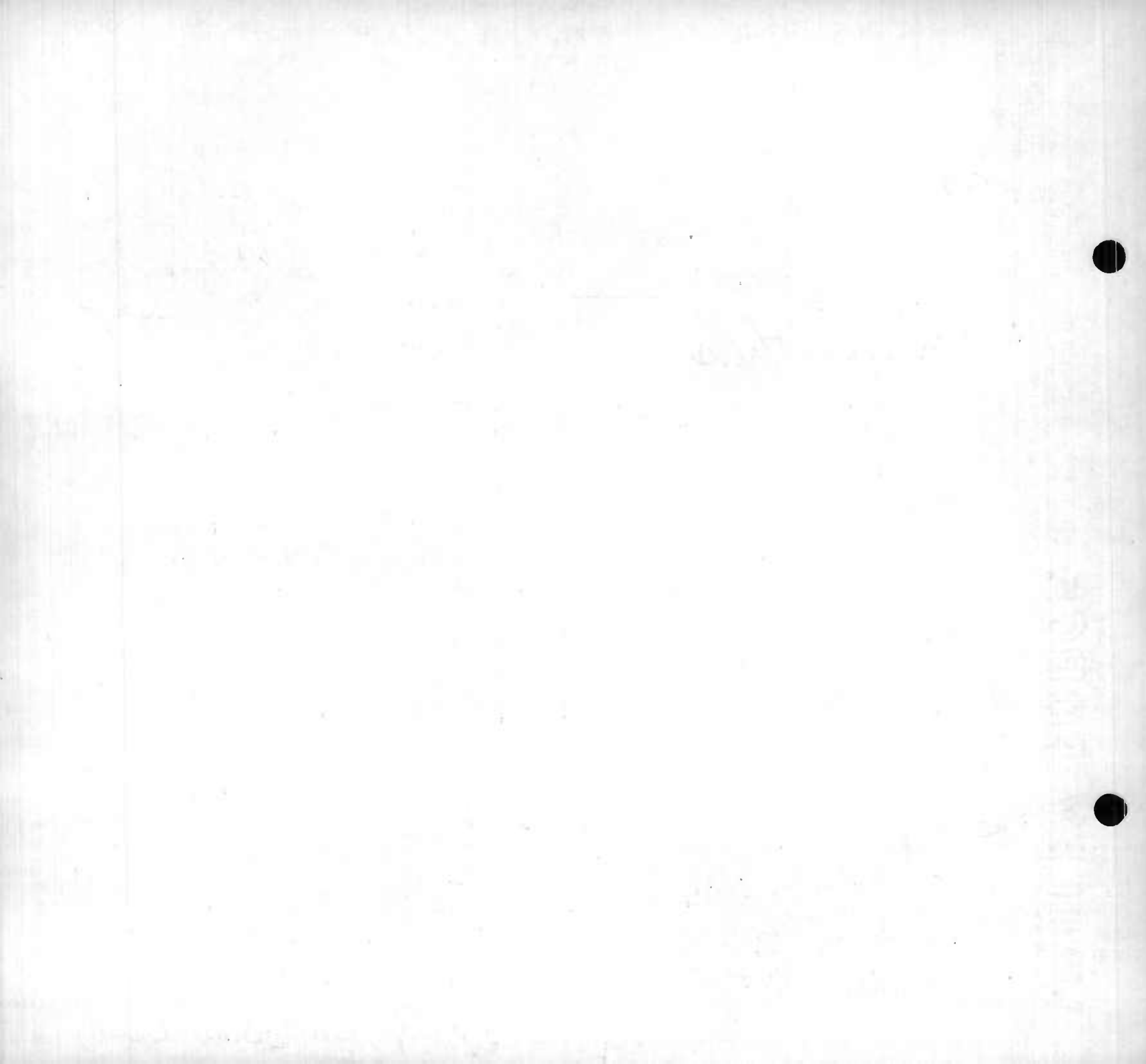
5 transcripts

returned

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8380		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8380	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) WALTER TRESS JR.		2. DATE AND HOUR OF DEATH 8-11-65		2 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Little Sisters of the Poor 1200 VALLEY ST. BALTIMORE MD 21202		A. STATE MD. B. COUNTY 10-01			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 1200 VALLEY ST.			
5. SEX M	6. RACE W	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH July 11, 1896	9. AGE (in years lost birthday) 69	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE	
13. FATHER'S NAME Walter Tress		14. MOTHER'S MAIDEN NAME Moll BERGER		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 216-10-7790		17. INFORMANT LITTLE SRS OF THE POOR	
18. 420.14-143X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) MASSIVE CORONARY OCCLUSION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. A.S.C.V.D. Squamous Cell carcinoma of mouth floor.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1964 to June 11 1965, that (I) (we) lost saw the deceased alive on June 11 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stanley Ankudas		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8.12.65	
23C. PHYSICIAN'S NAME (Type) STANLEY ANKUDAS		23D. ADDRESS M.D. 1802 W BALTIMORE ST			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/14/65	24C. NAME of CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. AUG 13 1965		25B. NAME OF REGISTRAR Philip Herwig Sons		25C. FUNERAL DIRECTOR Philip Herwig Sons	
				ADDRESS 2024 Orleans St	



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65 8381

BALTIMORE CITY HEALTH DEPARTMENT

65 8381

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MILDRED MARLENE COLE

2. DATE AND HOUR PRONOUNCED DEAD

August 12, 1965

5:30 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Joseph's Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3829 Bonview Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

7/13/1936

9. AGE (In years
last birthday)

29

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SOCIAL

10B. KIND OF BUSINESS OR INDUSTRY

SECURITY BLDG

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

EARL MYERS

14. MOTHER'S MAIDEN NAME

MILDRED MYERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

216-32-2308

17. INFORMANT

ADDRESS

JOHN A. COLE 3829 BONVIEW AVE.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) Arteriosclerotic Heart Disease.
DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/13/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

8/16/65

23C. NAME of CEMETERY or CREMATORY

BALTO. NATIONAL

23D. LOCATION

(City, town, or county)

BALTO. CO.

(State)

MD.

24A. DATE REC'D BY HEALTH DEPT.

AUG 13 1965

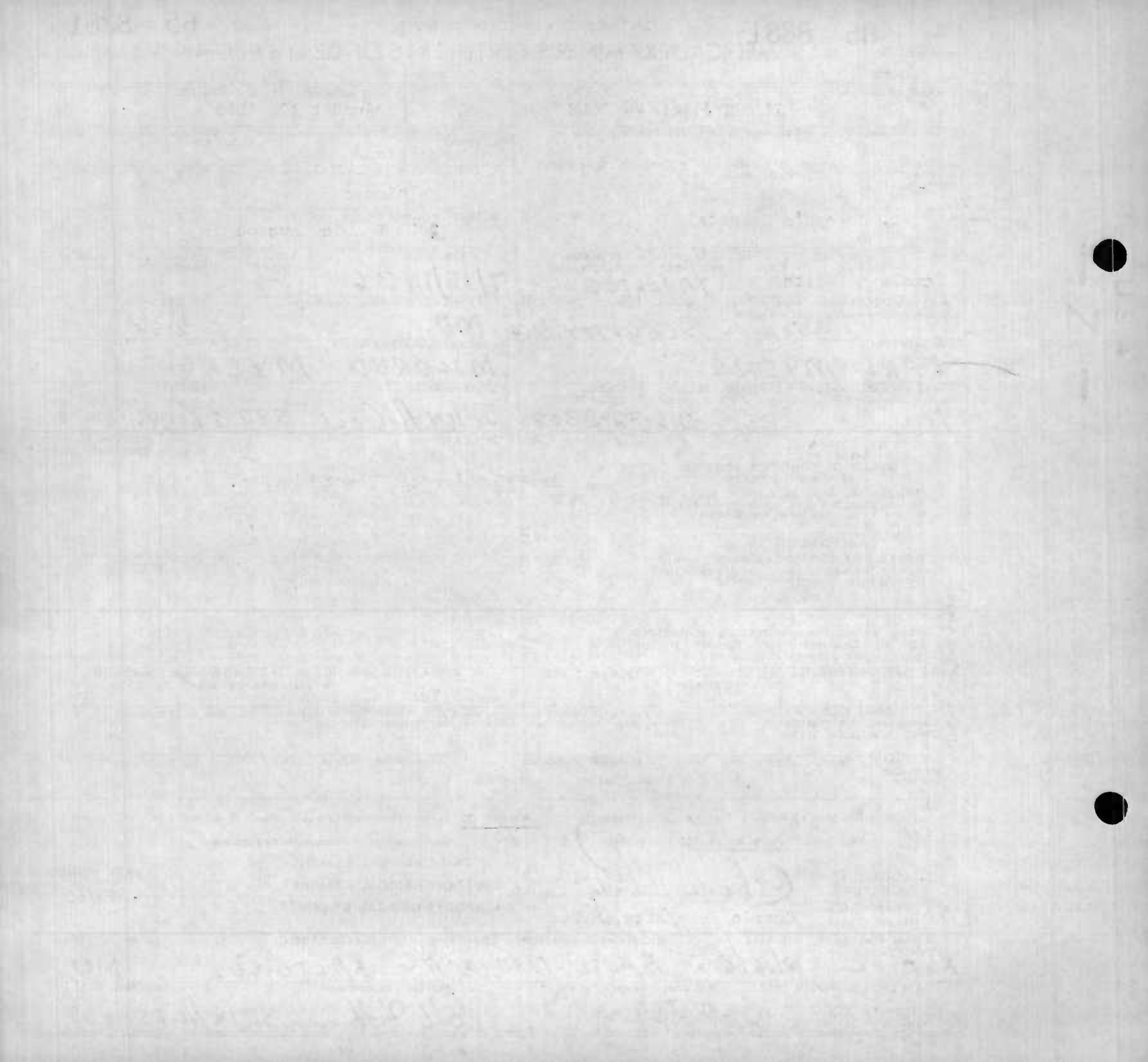
24B. NAME OF REGISTRAR

Robert E. Farkley, M.D.

24C. FUNERAL DIRECTOR

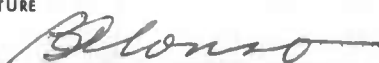
G. W. Hoffmann 3218 Hudson St.

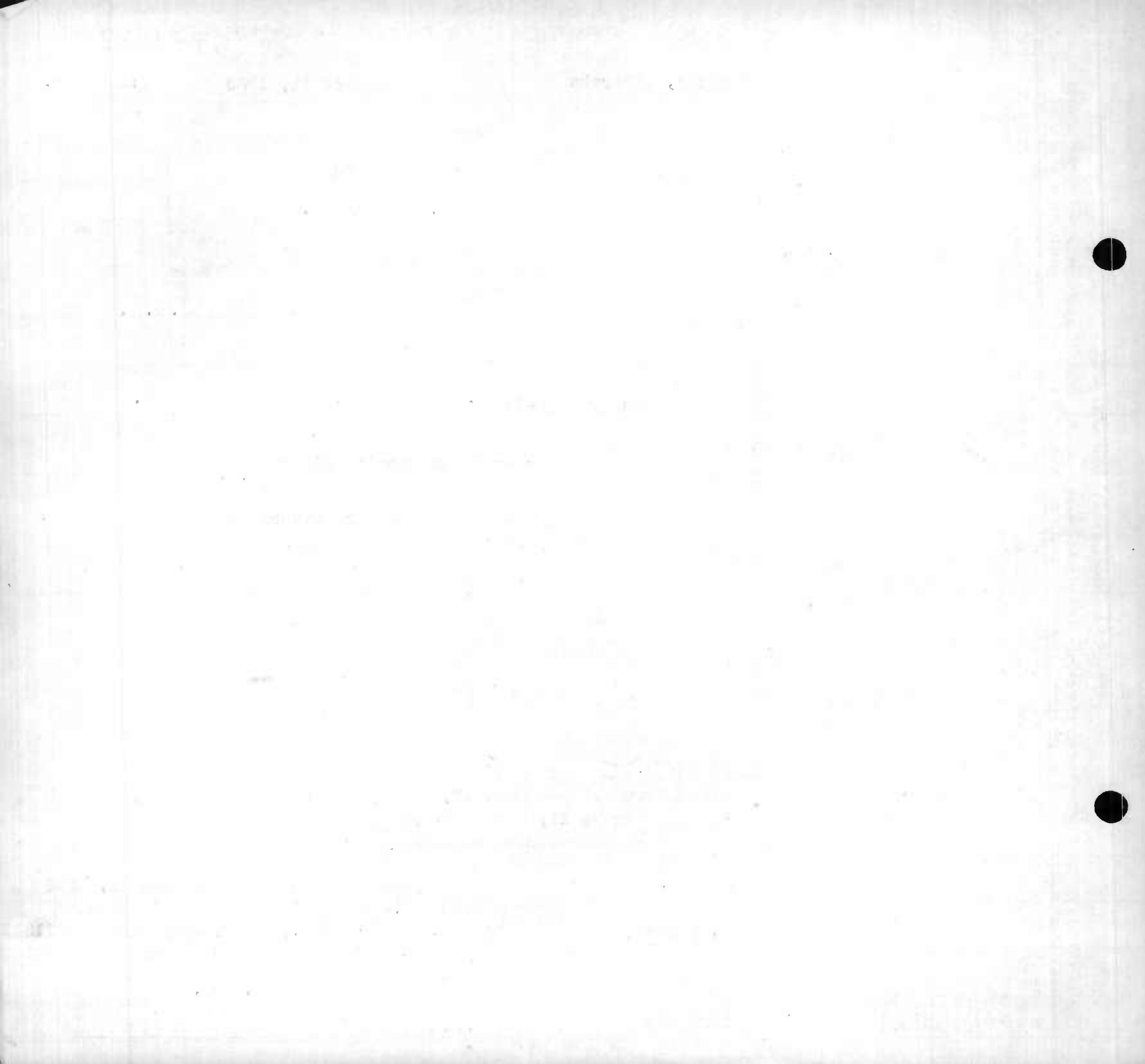
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

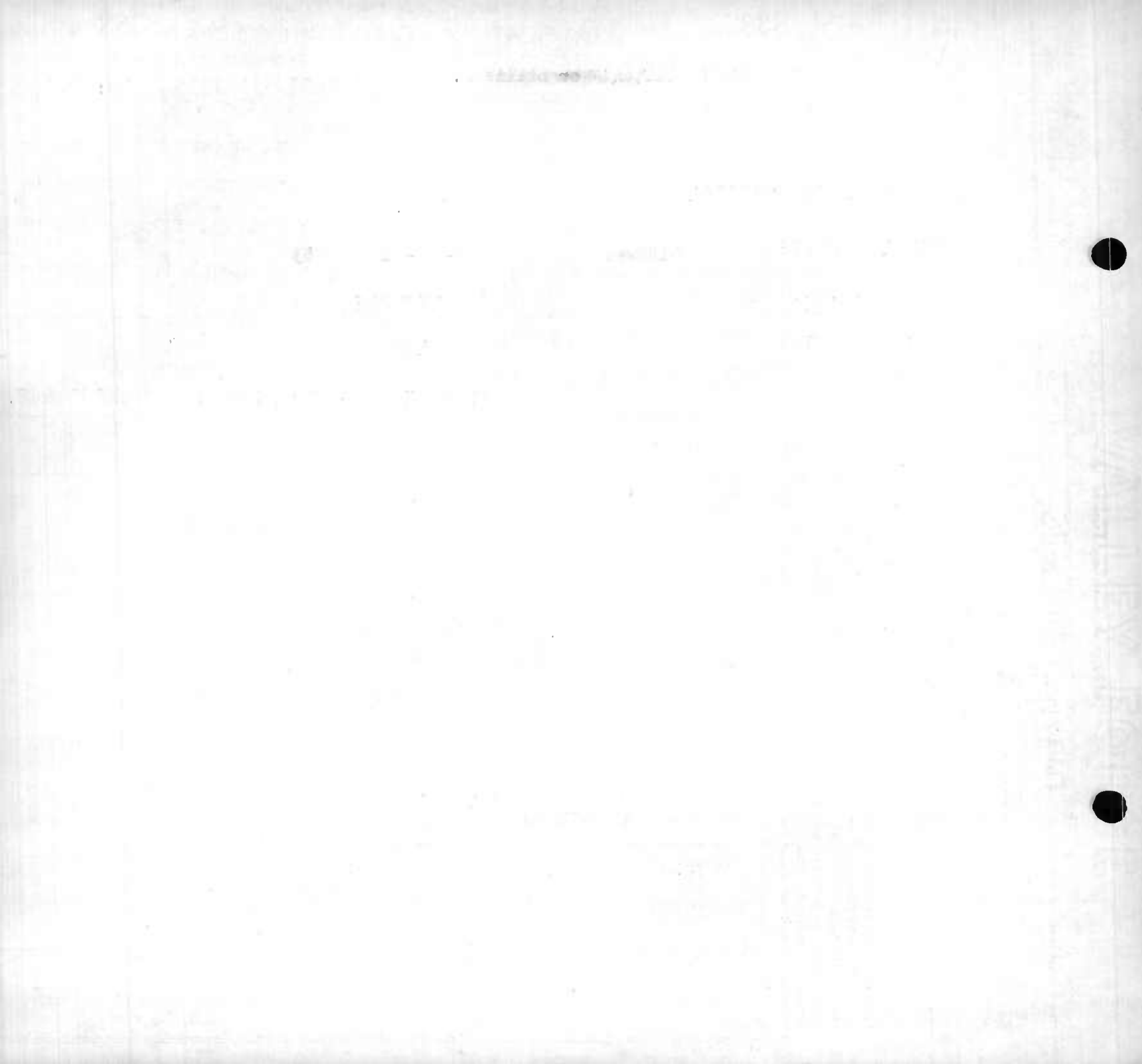
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8382	
BIRTH NO. 65 8382		CERTIFICATE OF DEATH			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
NOTARANGELO, Notarangelo, Liberata		August 11, 1965		1:16 P. M.	
3. PLACE OF DEATH		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
BALTIMORE, MARYLAND		A. STATE Maryland			
FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
St. Joseph Hospital		Baltimore 21224			
		D. STREET ADDRESS (If rural, give location)			
		603 S. Decker Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days
Female	White	Married	March 8, 1882	83	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Homemaker		Retired Men Clothing	Italy		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
PHILLIP VITELLO			MARY D'ADAMO		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		
NO		212-10-5621	MR. FELICE NOTARANGELO 603 S. Decker		
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from July 17, 19 65 to August 11, 19 65, that (I) (we) last saw the deceased alive on August 11, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
				August 11, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Bernardino A. Alonso,		M.D. 1400 N. Caroline St., Baltimore, Maryland 21213			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		8/14/65		HOLY REDEEMER 4400 BELAIR RD BALTO. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 13 1965		Robert E. Taylor		Frank G. Voe 322 S. High St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 8383					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 65 8383				
1. NAME OF DECEASED (Type or Print) BECKHARDT Lillian A or Lillie A.					2. DATE AND HOUR OF DEATH AUGUST 11 1965 10:50 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Howard C. CITY OR TOWN (If outside city limits, write RURAL and give township) HANOVER D. STREET ADDRESS (If rural, give location) Hanover Road				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 8-15-81	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME JOHN SMITH			14. MOTHER'S MAIDEN NAME HELENA Miller						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE.				
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) DUE TO Cerebral Thrombosis (B) DUE TO Intracerebral Thrombosis on recent apical myocardial infarction (C) Arteriosclerotic Cardiovascular Disease INTERVAL BETWEEN ONSET AND DEATH									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. atrial Fibrillation									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from JULY 25 19 65 to AUGUST 11 19 65 , that (I) (we) last saw the deceased alive on AUGUST 11 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE E.H. Weiss M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 8-11-65				
23C. PHYSICIAN'S NAME (Type) E.H. Weiss			23D. ADDRESS M.D. St. Agnes Hosp.						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/1965		24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. AUG 13 1965			25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR ADDRESS Balto., Md. 21217			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8384		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8384	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) DANIELS, BERTHA E.		2. DATE AND HOUR OF DEATH AUGUST 11, 1965 11:35 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4/ UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 12-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21218 D. STREET ADDRESS (If rural, give location) HOMWOOD APARTMENTS			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2/7/82	9. AGE (In years last birthday) 83	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM H. HOFFMAN		14. MOTHER'S MAIDEN NAME LAURA H. MERDE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. 212-48-1537		17. INFORMANT ADDRESS HOSPITAL RECORDS	
18. 5-01X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) frachio bronchitis. DUE TO electrolyte imbalance. (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/7 19 65 to 8/11 19 65 , that (I) (we) last saw the deceased alive on 8/11 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William R. Linton, Jr. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 8/12/65	
23C. PHYSICIAN'S NAME (Type) WILLIAM R. LINTON, JR., M.D.				23D. ADDRESS UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/1965		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION (City, town, or county) (State) Pikesville, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 13 1965			
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Wm. J. Fisher & Sons North Pa. ave.			

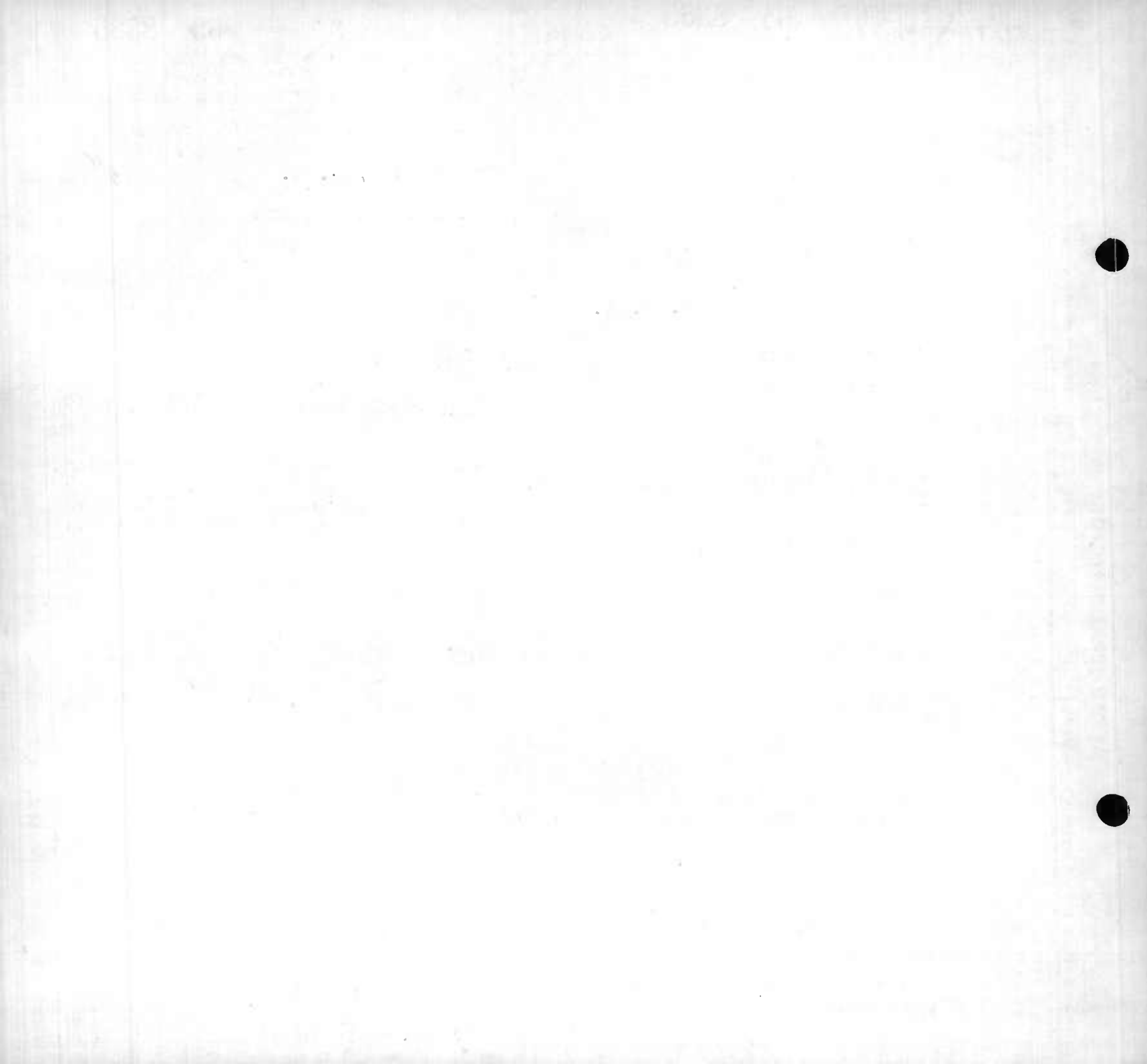
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

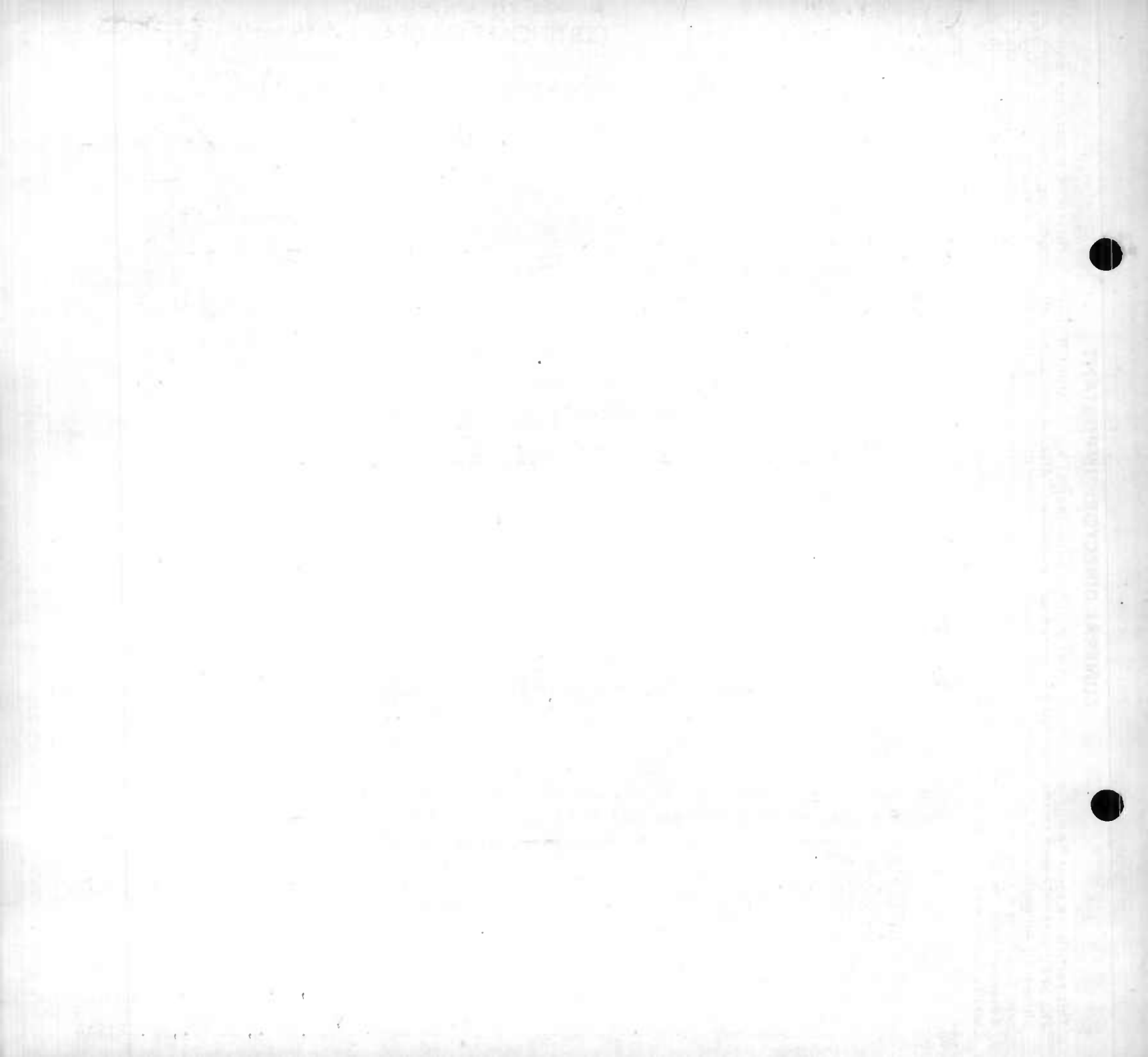
BIRTH NO. 65 8385		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8385	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Pfoost, Gracie		2. DATE AND HOUR OF DEATH Aug 11, 1965 10:55 A.M. 10:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Washington, D.C. Hotel Congressional		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Washington, D.C. V-48	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital Baltimore, Maryland		D. STREET ADDRESS (If rural, give location) Hotel Congressional			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 03-12-06	9. AGE (In years lost birthday) 37	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Governor		10B. KIND OF BUSINESS OR INDUSTRY F. H. A.		11. BIRTHPLACE (State or foreign country) Arkansas	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Bowers		14. MOTHER'S MAIDEN NAME Lily Wood	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ethel Ellis Boise, Idaho	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the made at dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 201X I Septemic shock		INTERVAL BETWEEN ONSET AND DEATH 5 hours			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Hodgkins disease		(B) DUE TO		2 years	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 7/9 to 8/11 1965 to 8/11 1965, that (I) (we) lost the deceased alive on 8/11/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Philip Horowitz		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/11/65	
23C. PHYSICIAN'S NAME (Type) Philip Horowitz		23D. ADDRESS c/o Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/17/65		24C. NAME of CEMETERY or CREMATORY Meridian Cemetery	
24D. LOCATION (City, town, or county) (State) Meridian Idaho		25A. DATE REC'D BY HEALTH DEPT. AUG 13 1965		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Jr. Wm. Lees Sons		ADDRESS Washington, D.C.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65-8386	
BIRTH NO. 65 8386		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Bush, Bruce Richard		2. DATE AND HOUR OF DEATH 12 August 1965 6:45 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21 D. STREET ADDRESS (If rural, give location) 1648 French's Ave.			
5. SEX Male	6. RACE Cauc.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH 4-7-63	9. AGE (In years last birthday) 2	11. BIRTHPLACE (State or foreign country) Maryland		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child			10B. KIND OF BUSINESS OR INDUSTRY -		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Harry Warren Bush Jr.			14. MOTHER'S MAIDEN NAME Phyllis A. McGhee				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Hosp. Chart - Father		
18. 75-6-21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) DUE TO Biliary Cirrhosis		2y.	
				(B) DUE TO Congenital Biliary Atresia		2y.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. -							
19A. DATE OF OPERATION June 1963		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Diagnosis of Condition		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nailly medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -			
21D. TIME OF INJURY (APPROX.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> - Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -			
22. I certify that (this hospital) attended the deceased from August 9, 1965 to August 12, 1965 , that (we) lost the deceased alive on 12 August 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE Edward J. Ruley M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED 12 August 1965	
23C. PHYSICIAN'S NAME (Type) Edward J. Ruley M.D.				23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/14/65		24C. NAME of CEMETERY or CREMATORY GARDENS OF FAITH CEMETERY		24D. LOCATION (City, town, or county) (State) BALTO, MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 13 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS LEONARD J. BUCK, INC., BALTO., MD. 21214			



1
65 8387
BALTIMORE CITY HEALTH DEPARTMENT
65 8387
BIRTH NO. 65 8387
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO. _____

1. NAME OF DECEASED (Type or Print) FRANK *10. Carl Gephhardt*

2. DATE AND HOUR PRONOUNCED DEAD August 11, 1965 4:59 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) *27-05*
3003 Westfield Avenue

5. SEX Male
6. RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) *married*
8. DATE OF BIRTH *Jan. 28, 1925*
9. AGE (In years last birthday) 40
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Plasterer*
10B. KIND OF BUSINESS OR INDUSTRY *Stebbing Co.*
11. BIRTHPLACE (State or foreign country) *Maryland*
12. CITIZEN OF WHAT COUNTRY? *USA*

13. FATHER'S NAME *Not known*
14. MOTHER'S MAIDEN NAME *Anna*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. *218184211*
17. INFORMANT *Lorraine E. Gephhardt*
ADDRESS *same*

18. *E 819.4*
CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
INTERVAL BETWEEN ONSET AND DEATH
(A) *Laceration of Heart*
DUE TO
(B) *Crushed Chest.*
DUE TO
(C) _____

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION *2*
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No) Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) *Street*
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) *Belair Rd., S. of Walter Ave. 53-00*

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) *8 11 '65 P*
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? *Passenger in auto into fixed object.*

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE *Charles S. Petty* M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) Charles S. Petty, M.D. ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED *8/12/65*
ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) *burial*
23B. DATE *8-16-65*
23C. NAME of CEMETERY or CREMATORY *Moreland Mem. Park*
23D. LOCATION (City, town, or county) (State) *Baltimore, Md.*

24A. DATE REC'D BY HEALTH DEPT. *AUG 30 1965*
24B. NAME OF REGISTRAR *Robert E. Fairbank*
24C. FUNERAL DIRECTOR *Leonard J. Ruck Inc Baltimore, Md.*
ADDRESS

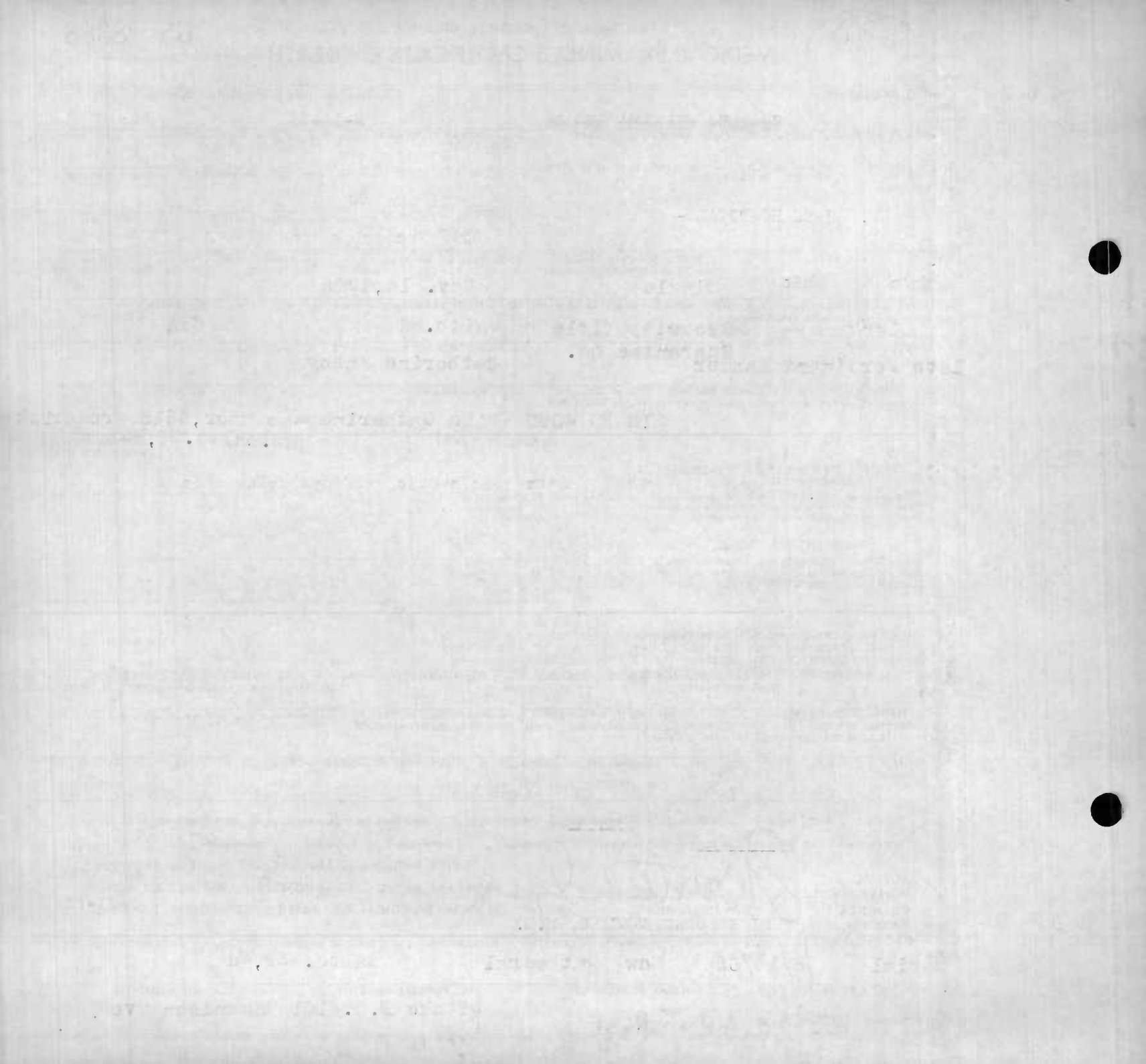
VS 151-REV. 1/1/65 *N 86912 6 5 0 0 0 7 9 0 1*

WALTER H. GIBBS

1915

K-560

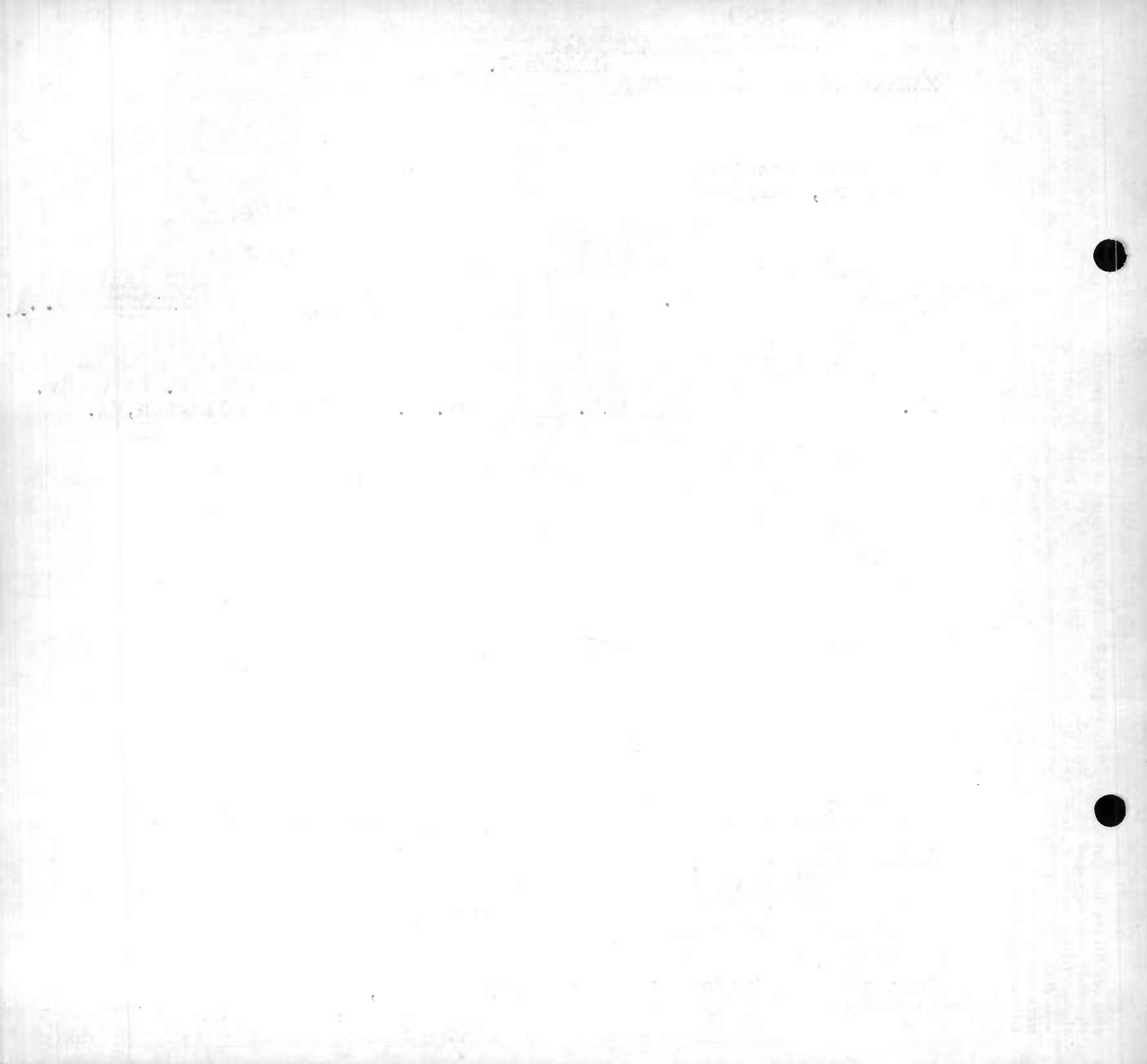
BALTIMORE CITY HEALTH DEPARTMENT				65 8388	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
BIRTH NO.		M.E. CASE NO.		1	
1. NAME OF DECEASED (Type or Print)		CHARLES WILLIAM KAMMER		2. DATE AND HOUR PRONOUNCED DEAD 8-11-65 10:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		B. COUNTY Baltimore	
ST. AGNES HOSPITAL - DOA		Baltimore 28		D. STREET ADDRESS (If rural, give location) 6515 Frederick Road	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Nov. 14, 1905	9. AGE (In years last birthday) 59	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Security Title		11. BIRTHPLACE (State or foreign country) Balto. Md	
13. FATHER'S NAME Late Ferdinand Kammer		14. MOTHER'S MAIDEN NAME Catherine Fahey		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown; If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212 20 4090		17. INFORMANT Miss Catherine K a mmer, 6515 Frederick	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH I Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		RUDIGER BREITENECKER, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 8/14/65		23C. NAME OF CEMETERY or CREMATORY New Cathedral	
24A. DATE REC'D BY HEALTH DEPT. AUG 13 1965		24B. NAME OF REGISTRAR Robert E. Fahey, M.D.		24C. FUNERAL DIRECTOR Witzke F.D. 4101 Edmondson Ave	
24D. LOCATION (City, town, or county) (State) Balto. 29, Md					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8389				BALTIMORE CITY HEALTH DEPARTMENT		CITY-CLERK DEPARTMENT		Registered No. 65 8389	
M.E. CASE NO. XXXXXXXXXXXXXXX				NAME OF DECEASED (Type or Print) William J Lawlor		2. DATE AND HOUR OF DEATH 8-11-65 6 35/4 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 4000 MASS AVE. North Washington DC. C. CITY OR TOWN (If outside city limits, write RURAL and give township) WASHINGTON D.C. V-48 D. STREET ADDRESS (If rural, give location) 4000 MASS AVE.					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secour Hospital Baltimore, Maryland				5. SEX M		6. RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10B. KIND OF BUSINESS OR INDUSTRY Unk.		8. DATE OF BIRTH 2-8-1910		9. AGE (In years last birthday) 55	
11. BIRTHPLACE (State or foreign country) IRELAND				12. CITIZEN OF WHAT COUNTRY? IRELAND U.S.A.		13. FATHER'S NAME William Lawlor		14. MOTHER'S MAIDEN NAME McCormack	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unk.				16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Mrs. J. Mc Elhone Arlington, VA.		ADDRESS 5035 N. 25 th St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 196.2 I CAUSE OF DEATH (A) CARCINOMA OF THE SPINE DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH				19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
19C. DATE OF OPERATION				19D. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE Antonio M. Estrada		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-11-65	
23C. PHYSICIAN'S NAME (Type) ANTONIO M. ESTRADA				23D. ADDRESS BON SECOURS HOSP					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 8/14/65		24C. NAME of CEMETERY or CREMATORY Gate of Heaven Wheaton, Maryland		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 13 1965				25B. NAME OF REGISTRAR Robert E. Parker		25C. FUNERAL DIRECTOR Joseph Gawlers Sons Inc		5130 WISCONSIN AVE N.W. WASHINGTON, D.C. 20016	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8390				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8390	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Columbus O'Donnell</i>				2. DATE AND HOUR OF DEATH <i>Aug. 12, 1965 13²⁵ PM M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>THE JOHNS HOPKINS HOSPITAL</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>27-38</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> D. STREET ADDRESS (If rural, give location) <i>5609 THE ALAMEDA, APT. A</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>Jan. 3, 1895</i>	9. AGE (In years last birthday) <i>70</i>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bookkeeper</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Miles & Stockbridge</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>JOHN HENRY O'DONNELL</i>				14. MOTHER'S MAIDEN NAME <i>ANNIE THERESA DEVILIN</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>WW I 215-01-4536</i>		17. INFORMANT <i>Mrs. Mary K. O'Donnell</i>		ADDRESS <i>(Same)</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>163 X I</i> <i>Ca B Lung</i>				INTERVAL BETWEEN ONSET AND DEATH <i>4 mo.</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Pneumonia</i>							
19A. DATE OF OPERATION <i>18/9/65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Secure dx possible palliation</i>		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <i>Aug 1</i> 1965 to <i>Aug 12</i> 1965, that (1) (we) last saw the deceased alive on <i>Aug 12</i> 1965 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. <i>Hour - 3:25 pm</i>							
23A. SIGNATURE <i>Walter Smithwick, M.D.</i>				23B. DATE SIGNED <i>8/12/65</i>			
23C. PHYSICIAN'S NAME (Type) <i>Walter Smithwick</i>				23D. ADDRESS <i>The Johns Hopkins Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/16/1965</i>		24C. NAME of CEMETERY or CREMATORY <i>Baltimore National</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 13 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR ADDRESS <i>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</i>			

to be long

the first time I have ever seen

Mother's hand

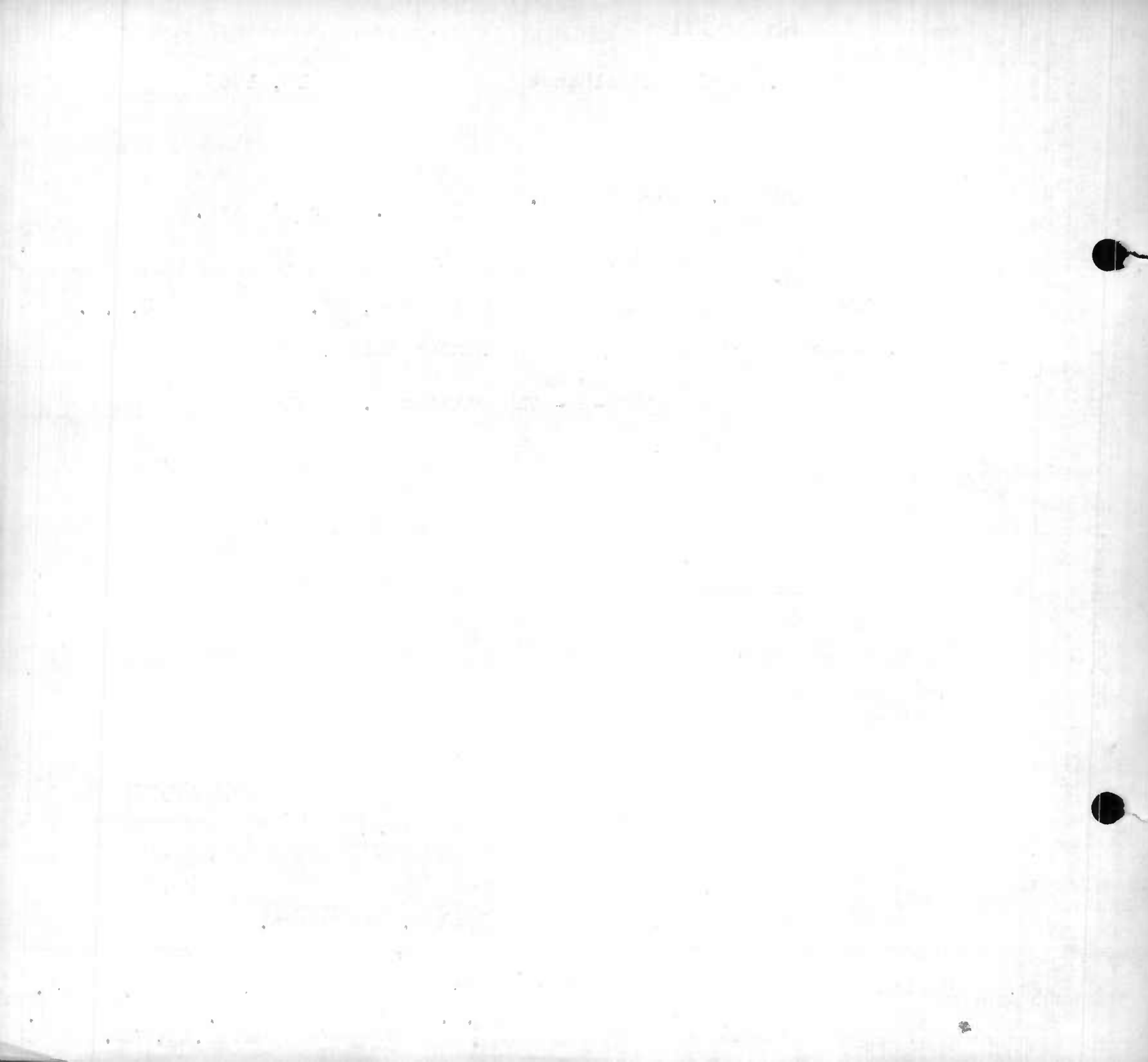
and so

1/2/12

FUNERAL DIRECTOR: IMPORTANT

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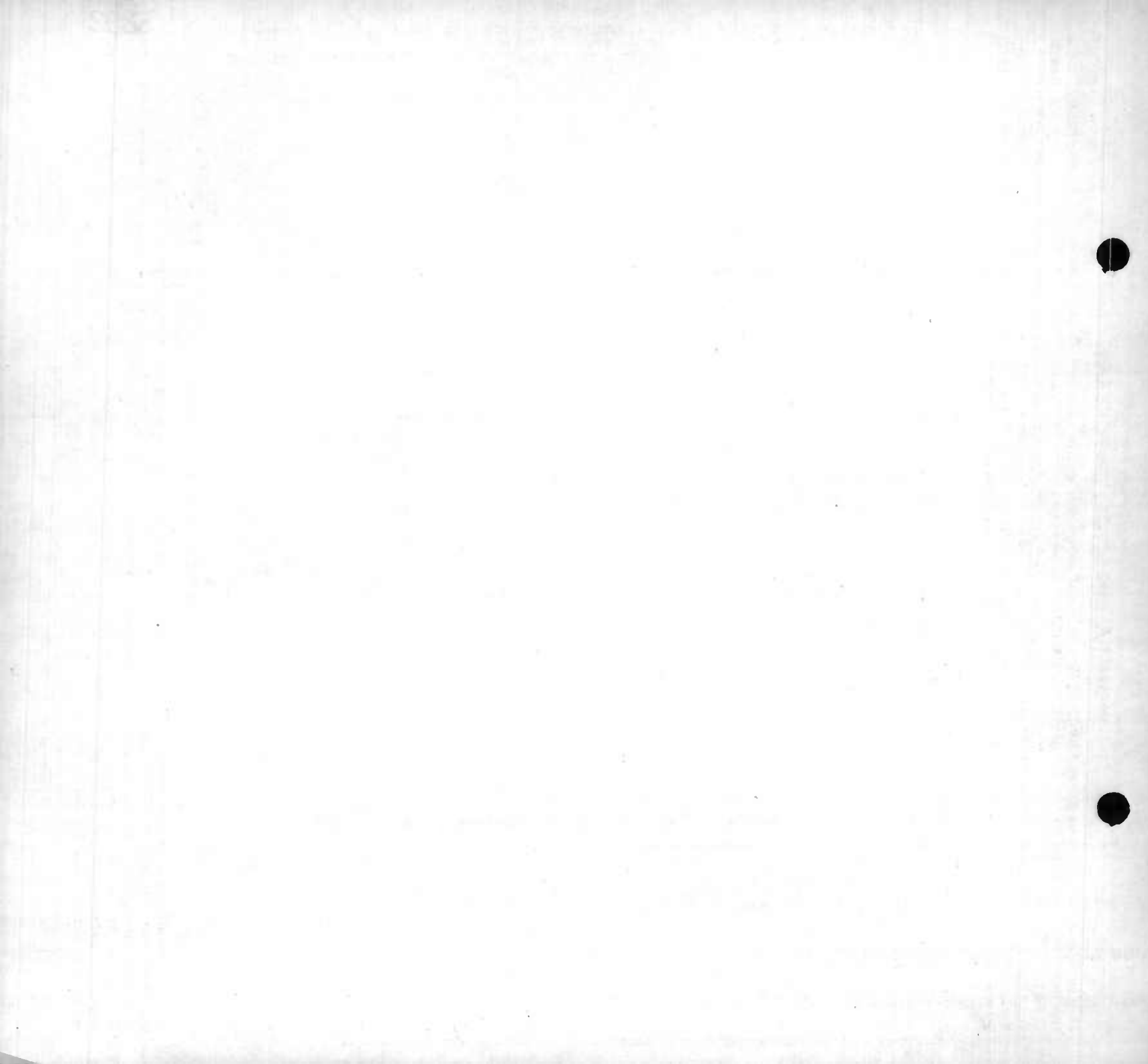
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8391	
BIRTH NO. 65 8391		CERTIFICATE OF DEATH		Registered No. 65 8391	
1. NAME OF DECEASED (Type or Print) Anna Katherine Engelhaupt			2. DATE AND HOUR OF DEATH August 10, 1965 1:00 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5309 St. George's Ave.			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 27-10 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5309 St. George's Ave.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4/1/1900	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME George Joeckel Trusheim			14. MOTHER'S MAIDEN NAME Hannah Reidinger		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-20-8714		17. INFORMANT William B. Engelhaupt	
				ADDRESS (Same)	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Coronary Thrombosis DUE TO (B) Atherosclerosis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH several hours
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/6/65 to 8/10/65, that (I) (we) last saw the deceased alive on 8/6/65 and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] M.D.			23B. DATE SIGNED 8/12/65		
23C. PHYSICIAN'S NAME (Type) Samuel Legum			23D. ADDRESS 1261 E. North Ave. M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/13/1965		24C. NAME of CEMETERY or CREMATORY Western Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 13 1965		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

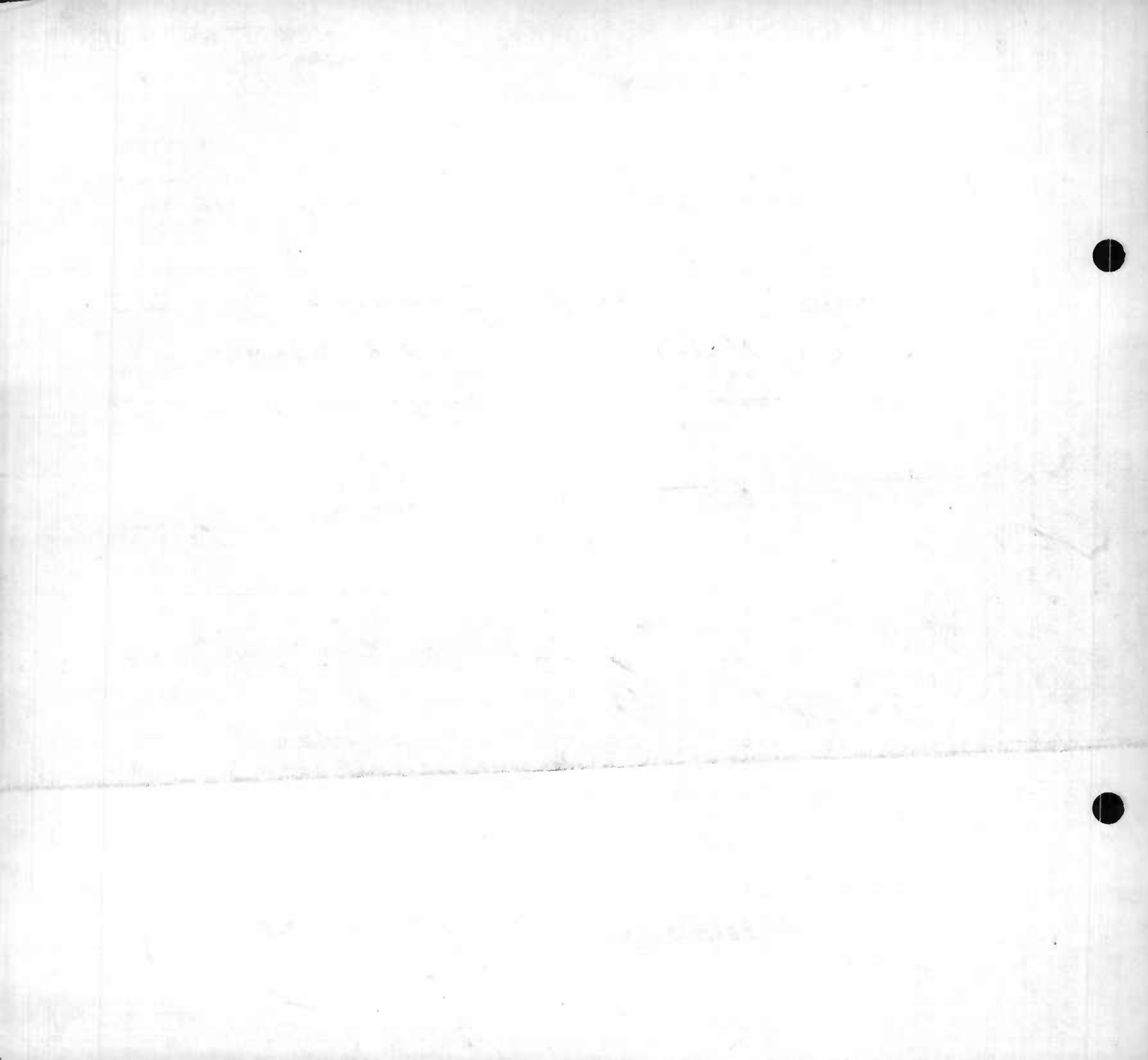
BIRTH NO. 65 8392		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 5 8392	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
GALLI, Raymond J.		8-12-65		3:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Mercy Hospital, Inc.		MARYLAND. ANNE ARUNDEL			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Severna Park 62-00			
		D. STREET ADDRESS (If rural, give location)			
		11 Severndale Rd.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. If Under 1 Yr. Months Days Hours Min.
M	W	MARRIED	9-27-30	34	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
ENGINEER		AERO-SPACE		Pennsylvania	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JAMES GALLI		TALERA SERVENT		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				MARY GALLI SAME	
18. 1950 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) Adrenal Tumor, malignant		3 days.	
ANTECEDENT CAUSES		(B) Arteriosclerotic heart disease		3 days.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Bronchopneumonia		3 days.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
No					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Aug 8 1965 to Aug 12 1965, that (H) (we) last saw the deceased alive on Aug 12 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Joseph A. Mead, Jr. M.D.				Aug 12, 1965	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Joseph A. Mead Jr. M.D.				605 BALTO-ANNA Blvd; Severna Park, Md	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8-16-65		Our Lady of Hope Cem.	
				Allegheny Co. Pa.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 16 1965		Robert E. Barranec		Severna Park, Md.	



FUNERAL DIRECTOR: IMPORTANT

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N-4001		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. 65 8393		CERTIFICATE OF DEATH X Registered No. 65 8393	
1. NAME OF DECEASED (Type or Print) GLENN B. NEILY		2. DATE AND HOUR OF DEATH 8-12-65 5:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY BALTO	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL of BALTIMORE, INC.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 6300	
		D. STREET ADDRESS (If rural, give location) 13 Tanglewood Rd. #28	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 11-19-55
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE	9. AGE (In years last birthday) 9
11. BIRTHPLACE (State or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph NEILY		14. MOTHER'S MAIDEN NAME LYDIA HERMAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —	17. INFORMANT ADDRESS Joseph H. Neily - 13 Tanglewood Rd.
18. 289.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cytic Fibrosis		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO	
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-9-65 to 8-12-65 , that (I) (we) last saw the deceased alive on 8-12-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death.			
23A. SIGNATURE Mardelle Buss		23B. DATE SIGNED 8-12-65	
23C. PHYSICIAN'S NAME (Type) MARDELLE BUSS		23D. ADDRESS Sinai Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-16-65	24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.	24D. LOCATION (City, town, or county) (State) Baltimore Md.
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR ADDRESS Tracy Evans & Co. Catonsville, Md.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 8394

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE

H

BERRY

(Bery)

2. DATE AND HOUR PRONOUNCED DEAD

August 12, 1965

4:00 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

A.A.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Annapolis

D. STREET ADDRESS (If rural, give location)

5 Wilson Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

8-12-1880

9. AGE (in years
last birthday)

85

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CIVIL SERVICE

10B. KIND OF BUSINESS OR INDUSTRY

U.S. GOVT.

11. BIRTHPLACE (State or foreign country)

VERMONT

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

William H. BERRY

14. MOTHER'S MAIDEN NAME

Mary ANN ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

YES

16. SOCIAL
SECURITY NO.

—

17. INFORMANT

GRACE E. BERRY

ADDRESS

4

18.

E9020

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Craniocerebral Injury.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

5 Wilson Road, Annapolis

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8 12 '65 P

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Fell off porch roof.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
8/13/6523A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

8-15-65

23C. NAME of CEMETERY or CREMATORY

Hillcrest

23D. LOCATION

(City, town, or county)

Annapolis

MD.

24A. DATE REC'D BY HEALTH DEPT.

AUG 16 1965

24B. NAME OF REGISTRAR

Robert E. Fadden

24C. FUNERAL DIRECTOR

John M. Taylor & Sons Annapolis Md.

ADDRESS

WALL TO WALL

8-12-88

10/12/88

10/12/88

10/12/88

10/12/88

10/12/88

10/12/88

10/12/88

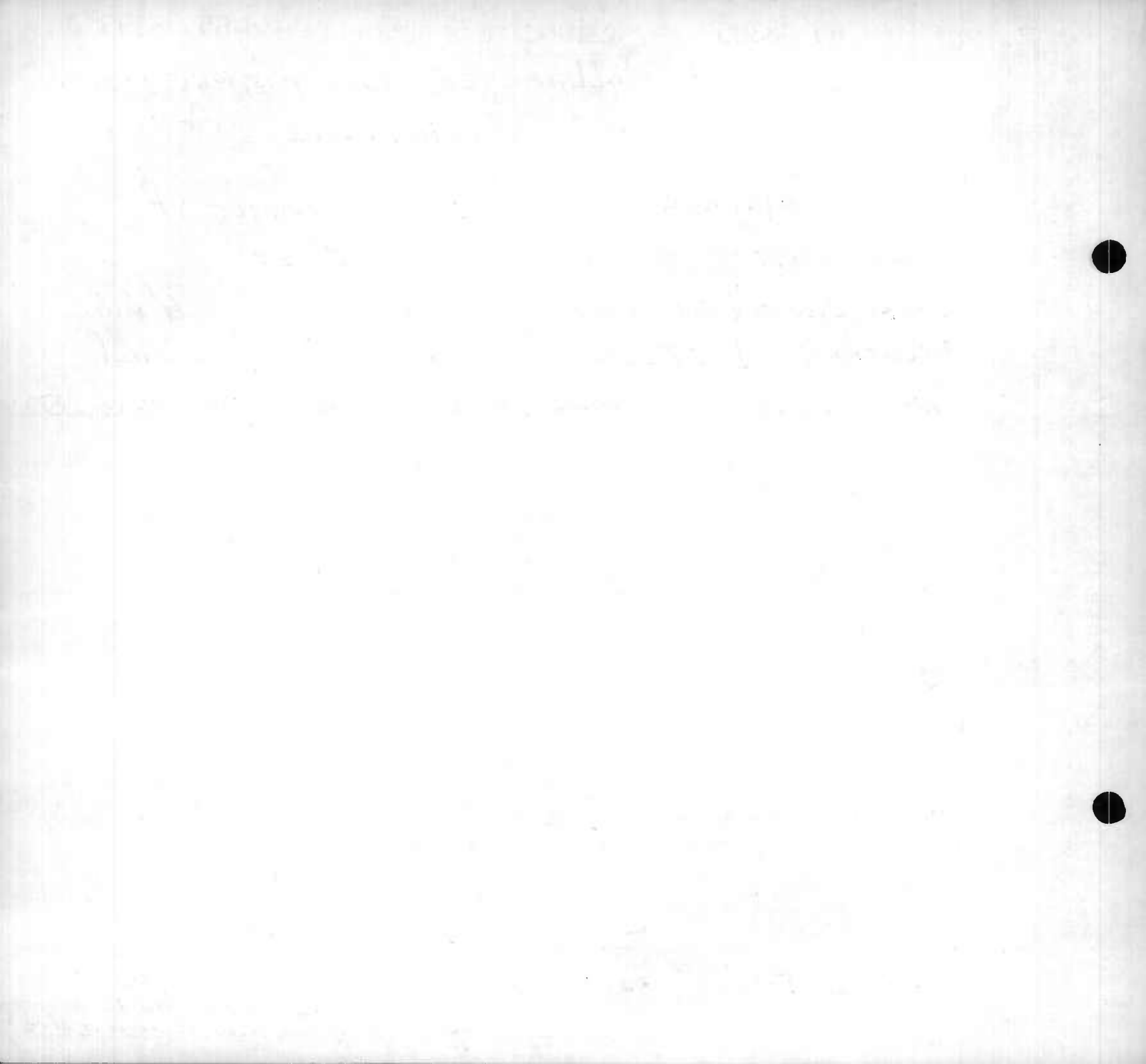
10/12/88

10/12/88

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8395	
BIRTH NO. 65 8395				CERTIFICATE OF DEATH	
M.E. CASE NO.				1. NAME OF DECEASED ADELE A. HALLAMEYER	
2. DATE AND HOUR OF DEATH August 13, 1965 1:15 P. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived; if institution, residence before admission) A. STATE Maryland B. COUNTY 19-04	
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) 219 S. Monroe St.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
				D. STREET ADDRESS (If rural, give location) 219 S. Monroe St.	
5. SEX FEMALE	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH March 19, 1905	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Press Operator			10B. KIND OF BUSINESS OR INDUSTRY Brush Mfg.		11. BIRTHPLACE (State or foreign country) GERMANY
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Frederick Dietzel		
14. MOTHER'S MAIDEN NAME Anna Ashenbach			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE		
16. SOCIAL SECURITY NO. 214-14-2081			17. INFORMANT ADDRESS KARL HALLAMEYER 219 S. Monroe St		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 260X1 Myocardial infarction				INTERVAL BETWEEN ONSET AND DEATH moment	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic CVD 15 years				Diabetes mellitus 15 years	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Peripheral vascular diseases					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 29 1968 to Aug 13 1965, that (I) (we) last saw the deceased alive on Jan 6 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did) (did not) view the body after death.					
23A. SIGNATURE Kennard Yaffe M.D.				23B. DATE SIGNED 8-13-65	
23C. PHYSICIAN'S NAME (Type) KENNARD YAFFE M.D.				23D. ADDRESS 5501 Forest Park Ave	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-16-65		24C. NAME OF CEMETERY or CREMATORY BALTO. NATIONAL	
24D. LOCATION (City, town, or county) BALTIMORE, Md.		24E. DATE REC'D BY HEALTH DEPT. AUG 16 1965		24F. NAME OF REGISTRAR Robert E. Fisher, M.D.	
24G. FUNERAL DIRECTOR EEO. L. Schwab		24H. ADDRESS Harrison Miller 2101 Frederick Ave			



BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 8390 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 8396

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RAYMOND C. FOUNTAIN

2. DATE AND HOUR PRONOUNCED DEAD

8/14/65 12:30 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

South Balto. General

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2705 Rittenhouse AVE.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

JAN 15 1929

9. AGE (In years
last birthday)

36

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

PACKER

10B. KIND OF BUSINESS OR INDUSTRY

MEAT PROCESSING MARYLAND

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WALTER F. W. FOUNTAIN, SR.

14. MOTHER'S MAIDEN NAME

CHARLOTTE BREMNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

YES World War II

16. SOCIAL
SECURITY NO.

217-24-3709

17. INFORMANT

ADDRESS

MARGARET FOUNTAIN 2705 RITTENHOUSE AVE.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/14/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

8-17-65

23C. NAME OF CEMETERY or CREMATORY

MEADOWRIDGE

23D. LOCATION (City, town, or county) (State)

ELK RIDGE MD

24A. DATE REC'D BY HEALTH DEPT.

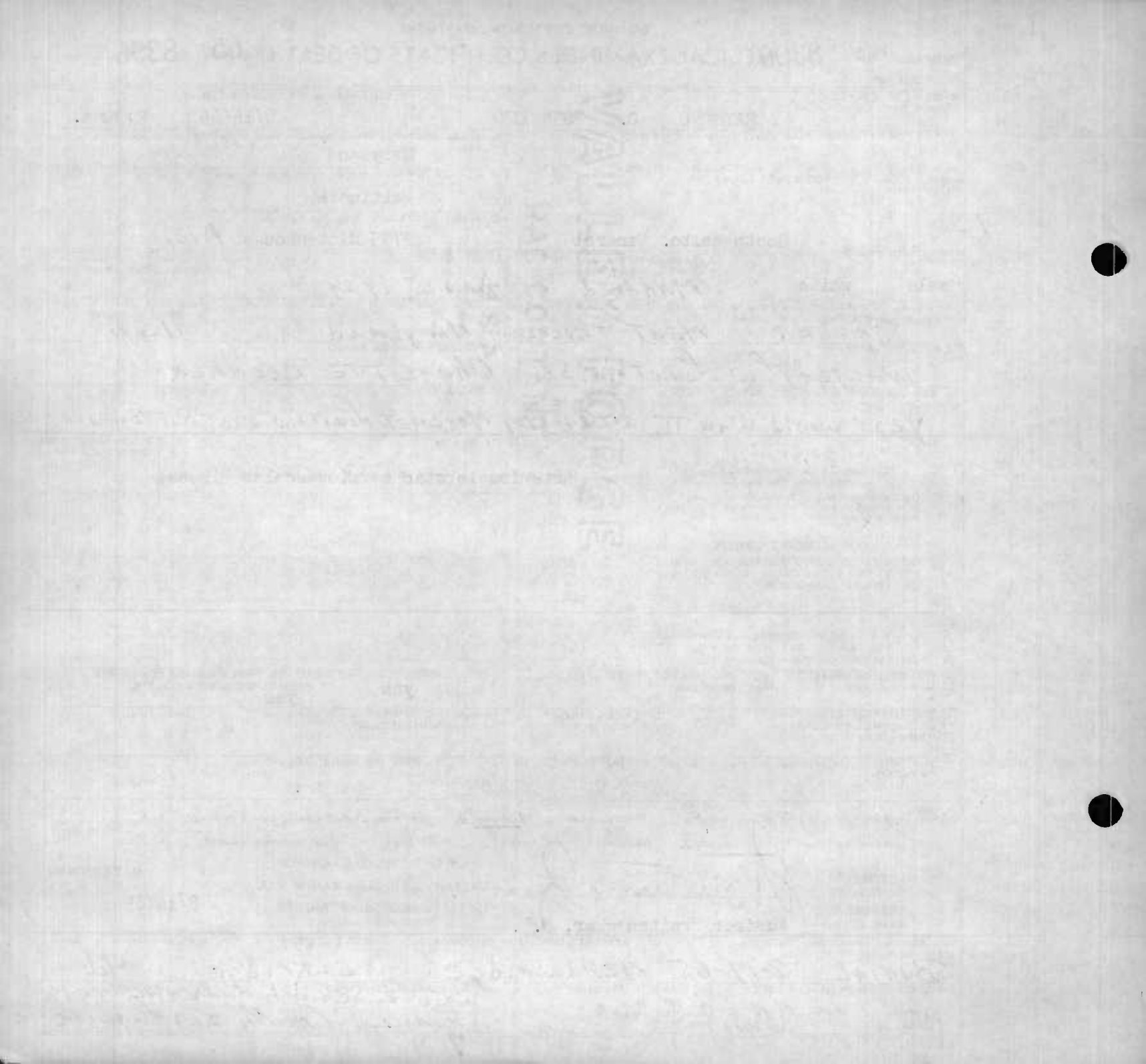
AUG 16 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

650 L. Schwab Avenue
Francis H. Miller 2101 Rudolph Ave.



BIRTH NO. 65 8397		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No. 65 8397	
M.E. CASE NO. K-452							
1. NAME OF DECEASED (Type or Print) ALFRED KLINGELHOEFER				2. DATE AND HOUR PRONOUNCED DEAD August 11, 1965 6:10 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Baltimore General Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pasadena 52-00 D. STREET ADDRESS (If rural, give location) Box 50, Route 2 (Fort Smallwood Road)			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Sept. 18, 1926	9. AGE (In years last birthday) 40 38	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10B. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter D. Klingelhoef (Sr)				14. MOTHER'S MAIDEN NAME Ethel Feit			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) yes 1946		16. SOCIAL SECURITY NO. 265 50 0435		17. INFORMANT Mrs. Roberta H. Klingelhoef (wife)		ADDRESS Same As #4	
18. CAUSE OF DEATH E 816.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) Cerebral Abscess DUE TO (B) Craniocerebral Injury. (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Mountain Rd. near Magothy Beach Rd.			
21D. TIME OF INJURY (APPROX.) 6 17 '65 P		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Driver in auto-auto collision. 52-00			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Petty, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type): Charles S. Petty, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/12/65							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE August 14/65		23C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Park		23D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
24A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		24B. NAME OF REGISTRAR Robert E. Farley, M.D.		24C. FUNERAL DIRECTOR Richard V. Singleton,		ADDRESS Glen Burnie, Md.	

xx 45

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8398				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8398	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MARY E. BAIN				2. DATE AND HOUR OF DEATH AUGUST 12, 1965 11:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4/ UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 13-08 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4230 FALLS ROAD			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 3/11/1890	9. AGE (In years lost birthday) 75	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE/CLERK		10B. KIND OF BUSINESS OR INDUSTRY HOME/SOCIAL SECURITY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ADAM PFAFF				14. MOTHER'S MAIDEN NAME ELIZABETH FOSSLER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-09-2308		17. INFORMANT SHIRLEY BIRMINGHAM		ADDRESS 109 MURDOCK RD. BALTIMORE 12, MD	
18. 465X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) massive pulmonary embolism				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO (B) DUE TO (C) DUE TO			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that the (this hospital) attended the deceased from AUGUST 12 1965 to AUGUST 12 1965 , that we (we) last saw the deceased alive on AUGUST 12 1965 and that in our (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE L. Evan Custer				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Aug. 12, 1965	
23C. PHYSICIAN'S NAME (Type) L. EVAN CUSTER,				23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 16-1965		24C. NAME of CEMETERY or CREMATORY London Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		25B. NAME OF REGISTRAR Robert E. Fairley		25C. FUNERAL DIRECTOR Burges Funeral Home		ADDRESS 3631 Falls Road	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8399		CERTIFICATE OF DEATH		Registered No. 65 8399	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Robert McMillion		2. DATE AND HOUR OF DEATH 8/12/65 6:40 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital		A. STATE MARYLAND, BALTIMORE		B. COUNTY Balto	
6. SEX Male		7. RACE White		8. DATE OF BIRTH 7-3-63	
9. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED		10. AGE (In years last birthday) 2		11. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto.	
13. FATHER'S NAME OSCAR McMILLION		14. MOTHER'S MAIDEN NAME BONNIE LAWRENCE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mather (Same as above)	
18. 193.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Metastatic Neuroblastoma		INTERVAL BETWEEN ONSET AND DEATH 5 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 30 1965 to August 12 1965, that (I) (we) last saw the deceased alive on August 12 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard W. Dodds		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Aug 12, 1965	
23C. PHYSICIAN'S NAME (Type) Richard W. Dodds		23D. ADDRESS cmc Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/65		24C. NAME OF CEMETERY or CREMATORY Balto. Cemetery	
24D. LOCATION (City, town, or county) Balto.		(State) Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Connelly 300 Mace Ave. Balto. 21	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

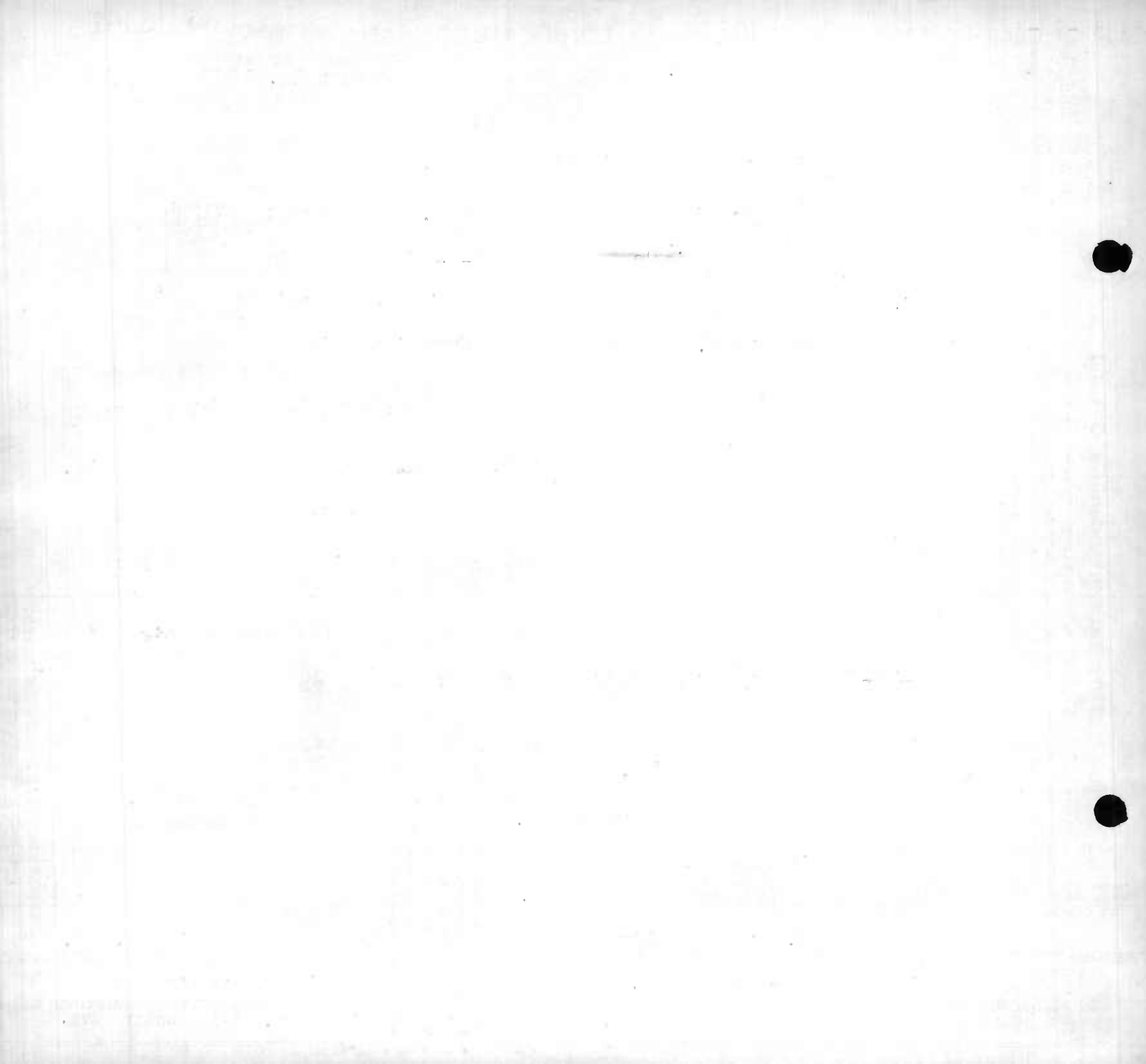
BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO.		65 8400		CERTIFICATE OF DEATH				Registered No. 65 8400			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH							
		LEHMAN JOHN JOHN H LEHMAN SR.		8-12-65				8 35 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY					
THE JOHNS HOPKINS HOSPITAL				MARY LAND		Balt					
				C. CITY OR TOWN		(If outside city limits, write RURAL and give township)					
				BALTIMORE		#20		53-00			
				D. STREET ADDRESS		(If rural, give location)					
				39 KERRIA LANE							
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. IF Under 1 Yr. Months Days		10. IF Under 24 Hrs. Hours Min.			
m	w	Married		12/24/02	62						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY					
				N.Y.		21. S.A.					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
Henry Lehman				Felicia Gray.							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS			
		135-09-4753		Wife (Same as above)							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH					
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) Myocardial Infarction				30 min					
ANTECEDENT CAUSES		(B) Arteriosclerosis				1960					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)									
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
0				No		No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
		While At Work <input type="checkbox"/> At Work <input type="checkbox"/>									
22. I certify that, (I) (this hospital) attended the deceased from 1960 to June 1965, that (I) (we) last saw the deceased alive on JUNE 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (and not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
J O Humphries				Aug 12, 65							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
J O Humphries				The Johns Hopkins Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)			
Burial		8/16/65		Gardens of Faith		Balt. Co.		Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR			
AUG 16 1965				Robert E. Farkes				Connolly 300 Mace Ave. Balt. 21			

VS: 35-98-47

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8401		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8401	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Leroy H. Langkam		August 11, 1965 5:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 26-10	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		31 N. East Street #21224			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 7-9-05	9. AGE (In years last birthday) 60	10. Under 1 Yr. Months; Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Frederick W. Langkam		14. MOTHER'S MAIDEN NAME Josephine Domier		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH: 4940 Eastern Avenue #24	
18. 540.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Pulmonary Embolus DUE TO Venous Thrombosis (B) ? DUE TO (C) Surgery for Peptic Ulcer		INTERVAL BETWEEN ONSET AND DEATH 5 Min. ? 8 Days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Severe Pulmonary Obstructive Disease		Many Years	
19A. DATE OF OPERATION 8-11-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding Peptic Ulcer		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 2, 1965 to August 11, 1965, that (I) (we) last saw the deceased alive on August 11, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Donald Baltzan		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 11, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. Donald Baltzan		23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, Md. #24			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-16-1965	24C. NAME of CEMETERY or CREMATORY Mt. Carmel		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		25B. NAME OF REGISTRAR Robert E. Faden		25C. FUNERAL DIRECTOR Lilly & Zeiler Inc. 1901 Eastern Ave.	



1
\$ 670

65 8402

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 8402

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print) Theresa DORSEY

2. DATE AND HOUR PRONOUNCED DEAD
8/14/65 8.15 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
DOA, 700 Fleet street

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 26-36

7. STREET ADDRESS (If rural, give location)
1125 Steelton Avenue

8. SEX female

9. RACE white

10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Divorced

11. DATE OF BIRTH
May 23, 1918

12. AGE (In years last birthday)
47

13. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housekeeper

15. KIND OF BUSINESS OR INDUSTRY
Own Home

16. BIRTHPLACE (State or foreign country)
Baltimore, Maryland

17. CITIZEN OF WHAT COUNTRY?

18. FATHER'S NAME
Paul Wojcik

19. MOTHER'S MAIDEN NAME
Sophia Giza

20. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No

21. SOCIAL SECURITY NO.

22. INFORMANT ADDRESS
George Wojcik 1125 Steelton Ave.

23. CAUSE OF DEATH

24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Fatty cirrhosis of liver

25. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

27. INTERVAL BETWEEN ONSET AND DEATH

28. DATE OF OPERATION

29. CONDITION FOR WHICH OPERATION WAS PERFORMED

30. AUTOPSY? (Yes or No)
yes

31. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes

32. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

33. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

34. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

35. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

36. INJURY OCCURRED

37. HOW DID INJURY OCCUR?

38. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

39. ACTUAL SIGNATURE EXAMINER'S NAME (Type)
R. Breiteneker

40. CHIEF MEDICAL EXAMINER ☐

41. ASSISTANT MEDICAL EXAMINER ☒

42. ASSOCIATE MEDICAL EXAMINER ☐

43. DATE SIGNED
8/15/65

44. BURIAL CREMATION, REMOVAL (Specify)
Burial

45. DATE
8-16-1965

46. NAME of CEMETERY or CREMATORY
St. Stanislaus

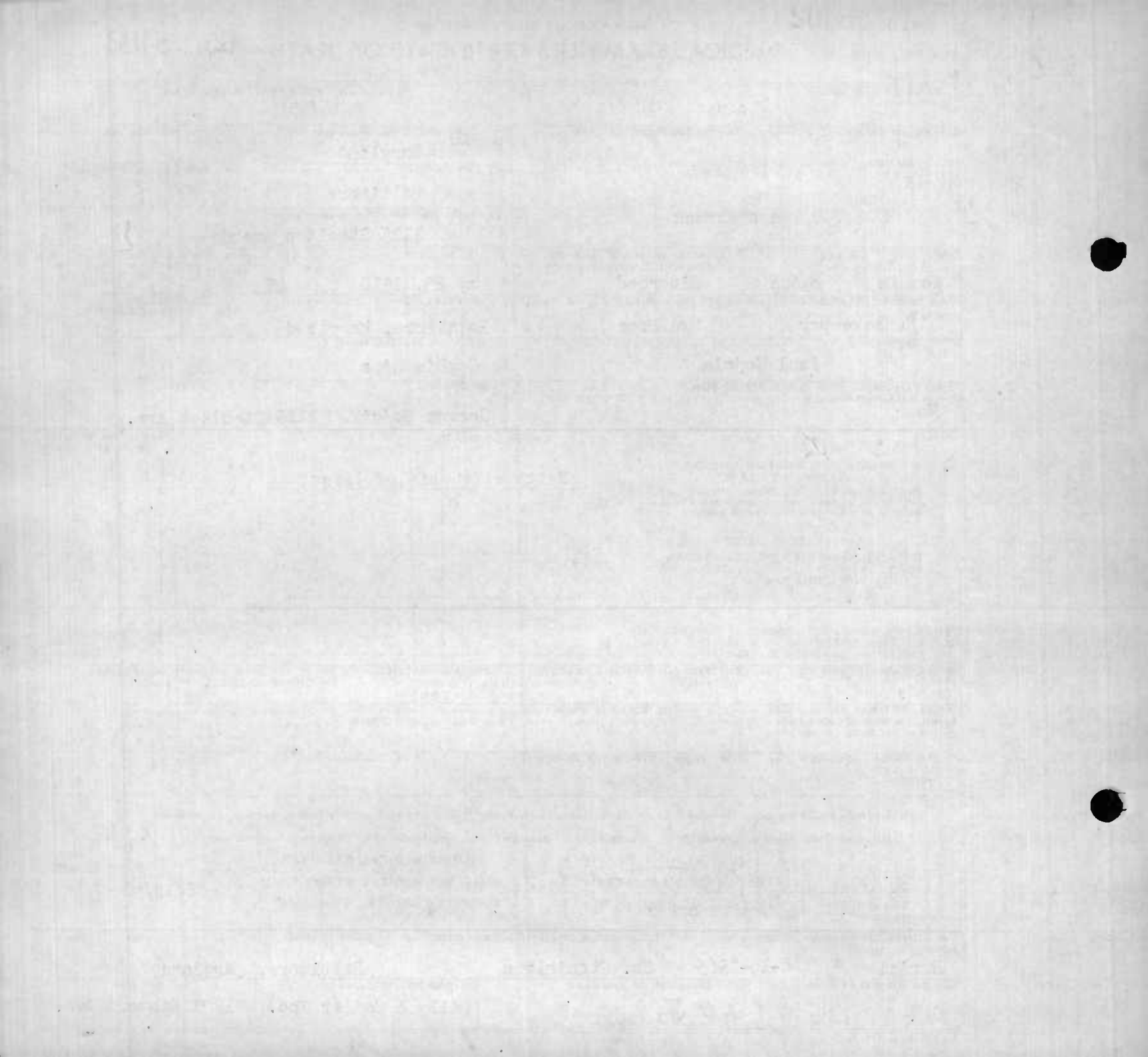
47. LOCATION (City, town, or county) (State)
Baltimore, Maryland

48. DATE REC'D BY HEALTH DEPT.
AUG 16 1965

49. NAME OF REGISTRAR
Robert E. Fairley

50. FUNERAL DIRECTOR ADDRESS
Lilly & Zeiler Inc. 1901 Eastern Ave.

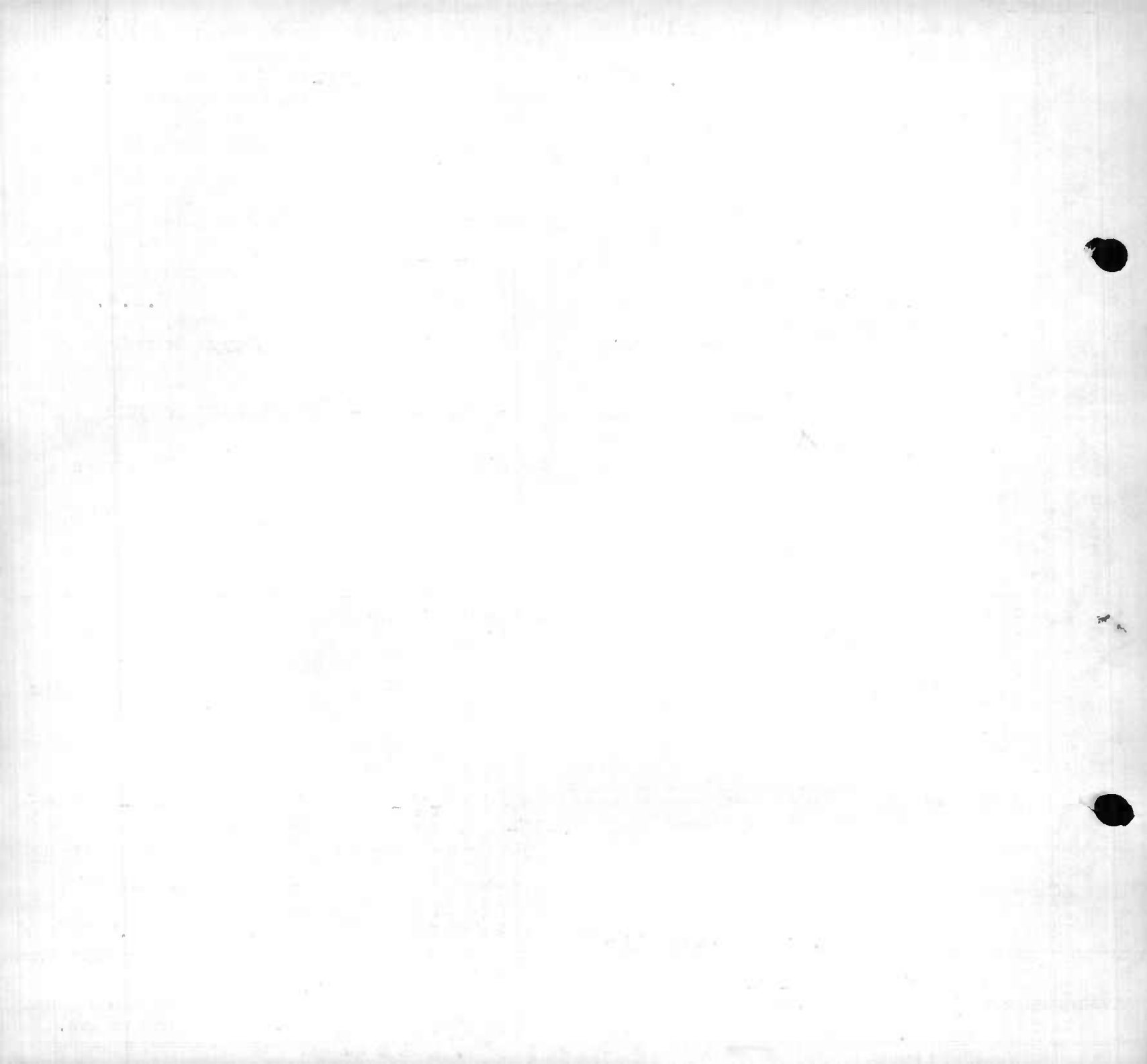
VS 151-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
M.E. CASE NO.		CERTIFICATE OF DEATH		65 8403	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
Louise B. Mueller		8-15-1965 4:00 A.M.		Baltimore, Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		5. SEX	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland		Maryland Baltimore		Female	
6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
White		Separated		6-18-1897	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
Housewife		Own Home		68	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Maryland		U.S.A.		George Davis	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Mary Semrod		No			
17. INFORMANT		18. CAUSE OF DEATH		19. DATE OF OPERATION	
Records: BCH-4940 Eastern Avenue 21224		(A) Sepsis DUE TO		20A. AUTOPSY? (Yes or No)	
12 hours		(B) DUE TO		Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(C) DUE TO		Yes	
6 hours		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Possible Pencillin or Blood Reaction	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-14-1965 to 8-15-1965, that (I) (we) last saw the deceased alive on 8-15-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
Barry Wayne Uhr		M.D. Attending Phys. Med. Director Staff Phys. <input checked="" type="checkbox"/>		8-15-1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)	
Dr. Barry Wayne Uhr		M.D. 4940 Eastern Avenue, Baltimore, Maryland		Burial	
24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
8-17-1965		Holy Redeemer		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 16 1965		Lilly & Zeiler Inc.		ADDRESS	
				1901 Eastern Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 65 8404					CERTIFICATE OF DEATH					Registered No. 65 8404									
1. NAME OF DECEASED (Type or Print) <u>John H. Bowler</u>					2. DATE AND HOUR OF DEATH <u>8/13/65</u> <u>12²⁰ a.m.</u>														
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>Baltimore</u>														
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u> <u>BALTIMORE, md</u>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Linthicum Heights</u> <u>52-00</u>														
					D. STREET ADDRESS (If rural, give location) <u>1305 River Rd.</u>														
5. SEX <u>m</u>		6. RACE <u>w</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>		8. DATE OF BIRTH <u>10/2/10</u>		9. AGE (In years last birthday) <u>54</u>		If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>uemp</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>fisherman</u>					11. BIRTHPLACE (State or foreign country) <u>Va.</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>John H. Bowler</u>					14. MOTHER'S MAIDEN NAME <u>Mattie Pursley</u>														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Sister ANNA E. BLAND.</u>					ADDRESS							
18. <u>334X1</u>					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)					(A) <u>Thrombosis of aorta</u>					<u>48 hrs.</u>									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) <u>—</u>														
					(C) <u>—</u>														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					<u>stroke (2), myocardial infarct</u>														
19A. DATE OF OPERATION <u>8/10</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>aortic aneurysm</u>					20A. AUTOPSY? (Yes or No) <u>no</u>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (1) this hospital attended the deceased from <u>8/5</u> <u>1965</u> to <u>8/13</u> <u>1965</u> , that (1) we last saw the deceased alive on <u>8/12</u> <u>1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.																			
23A. SIGNATURE <u>Robert M. Byers</u> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <u>8/13/65</u>									
23C. PHYSICIAN'S NAME (Type) <u>Robert M BYERS</u>					23D. ADDRESS <u>University Hospital</u>														
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>Aug. 15/65</u>					24C. NAME OF CEMETERY or CREMATORY <u>Grace Cemetery</u>					24D. LOCATION (City, town, or county) (State) <u>Rollins Fork, Virginia</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 16 1965</u>					25B. NAME OF REGISTRAR <u>Robert E. Feltner</u>					25C. FUNERAL DIRECTOR <u>R. V. Singleton</u>					ADDRESS <u>Glen Burnie, Md.</u>				

Coded according to
State Health Dept.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

8405
Romedy, CORNELIUS S.

2. DATE AND HOUR OF DEATH

10:00 PM

8/13/65

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

University Hospital.
Lombard + Greene Sts.

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE B. COUNTY

Maryland.

Balto

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

5300

D. STREET ADDRESS (If rural, give location)

1221 Brandford Road #2E.

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

12/03/05

9. AGE (in years
lost birthday)

59

If Under 1 Yr.
Months Days

If Under 24 Hrs.
Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

terminal manager

10B. KIND OF BUSINESS OR INDUSTRY

Modack Transportation

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Claude Romedy.

14. MOTHER'S MAIDEN NAME

Hula Crawford.

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

HOSP. REL. ROOM

ADDRESS

18. 434.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

Obstructive Airway Disease -

Acute Pulmonary Edema.

(B) DUE TO

Cor Pulmonale.

(C) DUE TO

Congestive Heart failure.

Feb 1969.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Ascites.

19A. DATE OF OPERATION

0 -

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 6/9/65 to 8/13/65
that (we) last saw the deceased alive on 8/13 1965 and that in (our) opinion death occurred on the date
and hour and from the causes stated above. (We) did (did not) view the body after death.

23A. SIGNATURE

E. Ann Robinson

M.D.

Attending
Phys.

Med.
Director

Staff
Phys.

23B. DATE SIGNED

8/13/65.

23C. PHYSICIAN'S
NAME (Type)

E ANN ROBINSON.

M.D.

23D. ADDRESS

University Hospital.

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

8/16/65

24C. NAME of CEMETERY or CREMATORY

SHARON MEM. PT. CHARLOTTE, N.C.

24D. LOCATION

(City, town, or county)

(State)

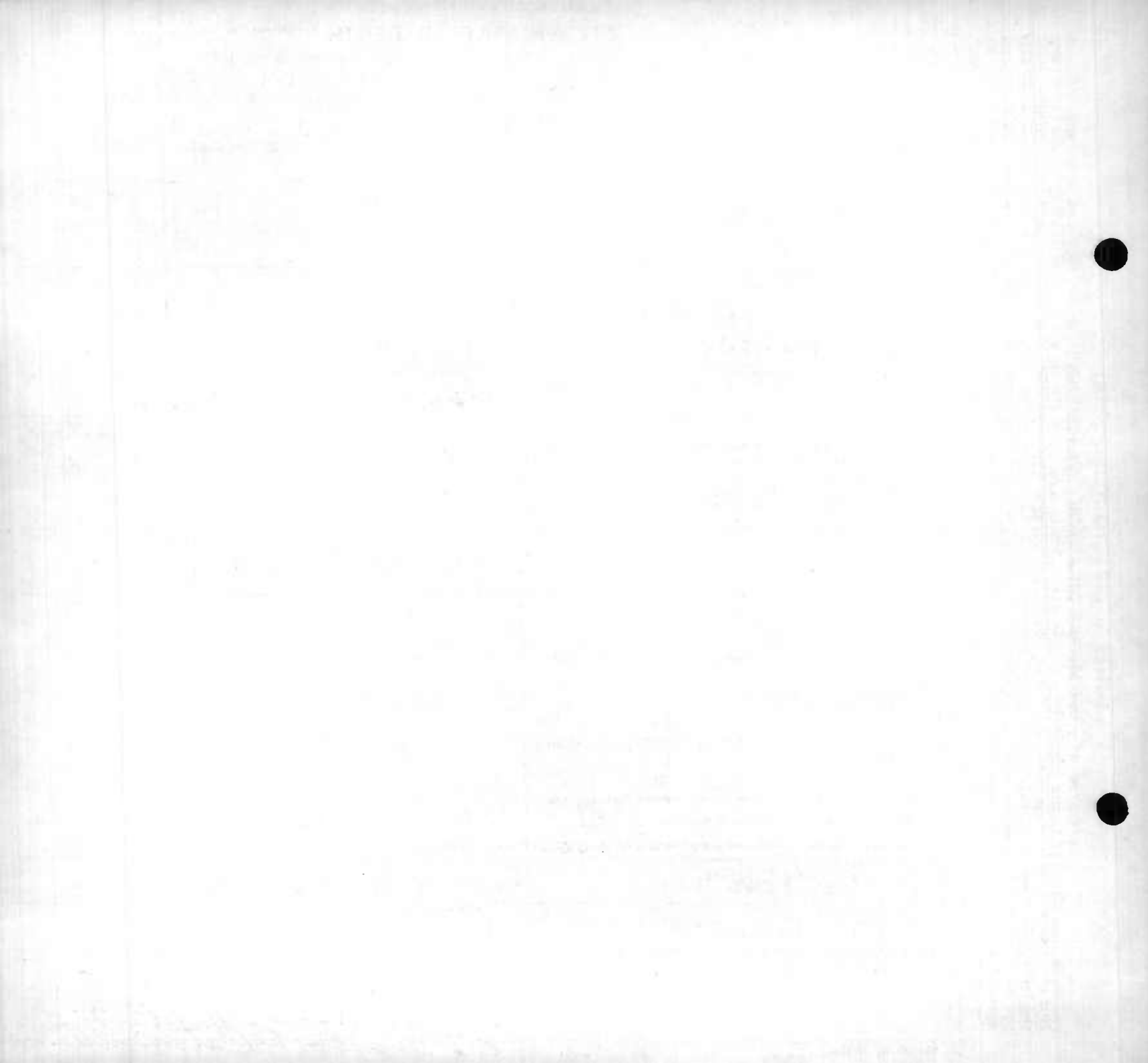
25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

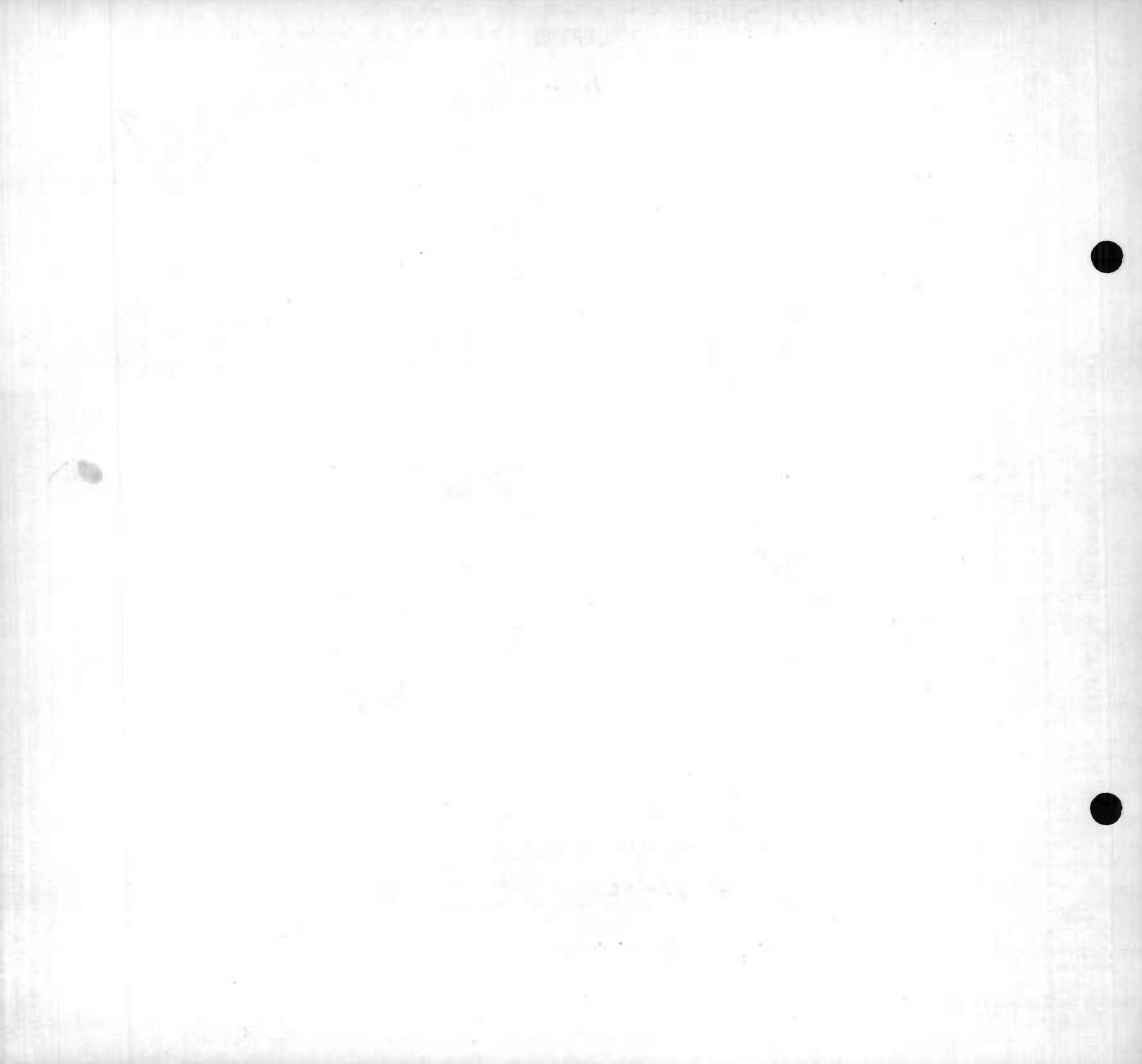
Miller + Kern Charlotte N.C.
25700 North Catonsville Md



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

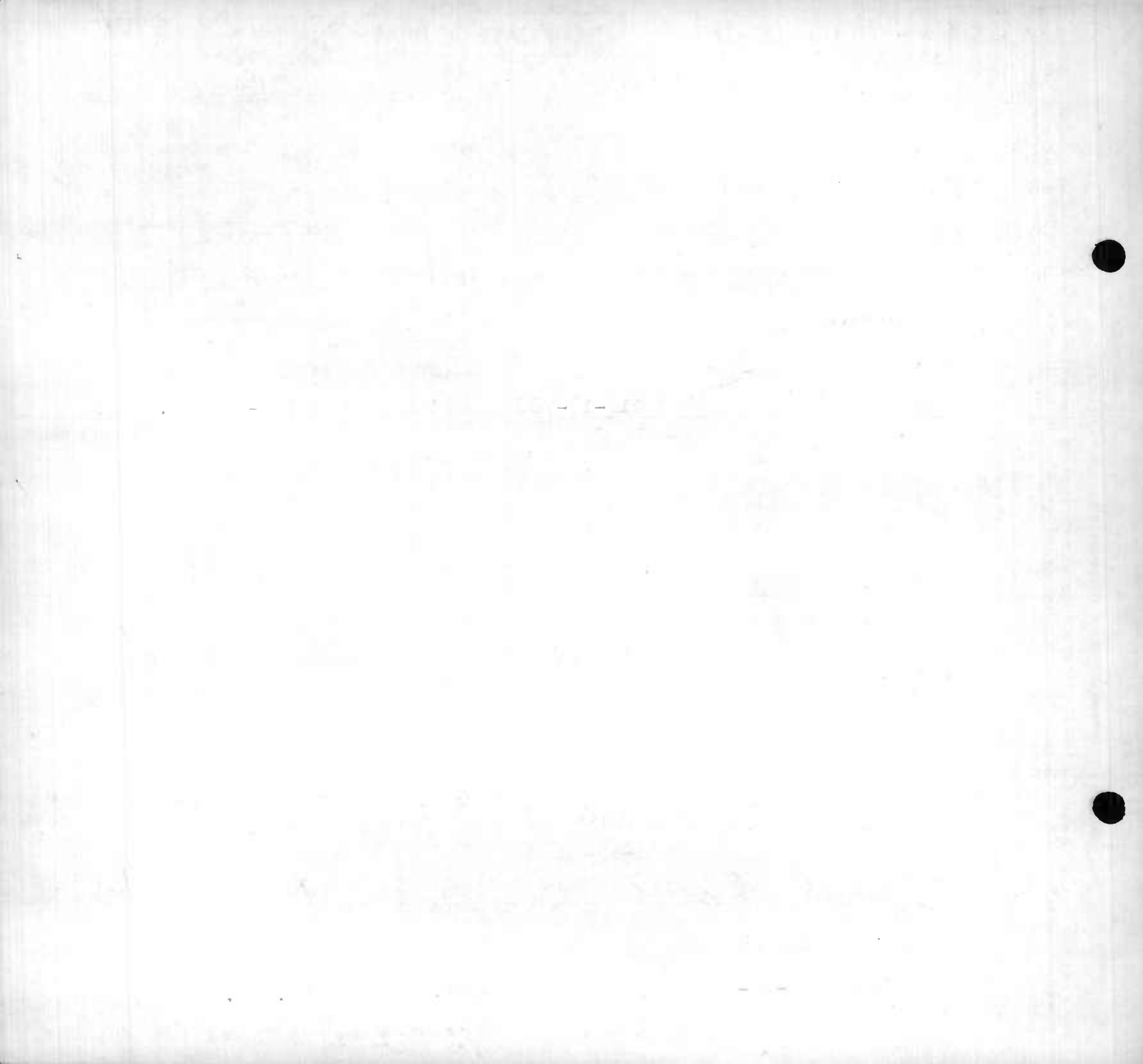
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 8406	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No. 8406	
1. NAME OF DECEASED (Type or Print) <i>Lula E. Wicklein.</i>			2. DATE AND HOUR OF DEATH <i>8-13-65 4:20 A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hosp.</i>			A. STATE <i>Maryland</i> B. COUNTY <i>23-83</i>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #2/230</i>		
			D. STREET ADDRESS (If rural, give location) <i>1536 Clarkson St.</i>		
5. SEX <i>F.</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>9-24-1883</i>	9. AGE (In years last birthday) <i>81</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Wm. Bailey</i>		14. MOTHER'S MAIDEN NAME <i>California Nunnally</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Jas. Standiford</i>	
18. <i>420.01</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Arteriosclerotic Vascular Heart Disease</i>			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from <i>8-11</i> 19 <i>65</i> to <i>8-13</i> 19 <i>65</i> , that the (we) last saw the deceased alive on <i>8-13</i> 19 <i>65</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Hugh J. Hargrave</i>				23B. DATE SIGNED <i>8-13-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Hugh J. Hargrave, M.D.</i>				23D. ADDRESS <i>South Baltimore General Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-16-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Meadowridge</i>	
24D. LOCATION (City, town, or county) (State) <i>Dorsey Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 16 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Fadden</i>		25C. FUNERAL DIRECTOR ADDRESS <i>McCully Funeral Home 130 E. Fort Ave</i>			



FUNERAL DIRECTOR: IMPORTANT

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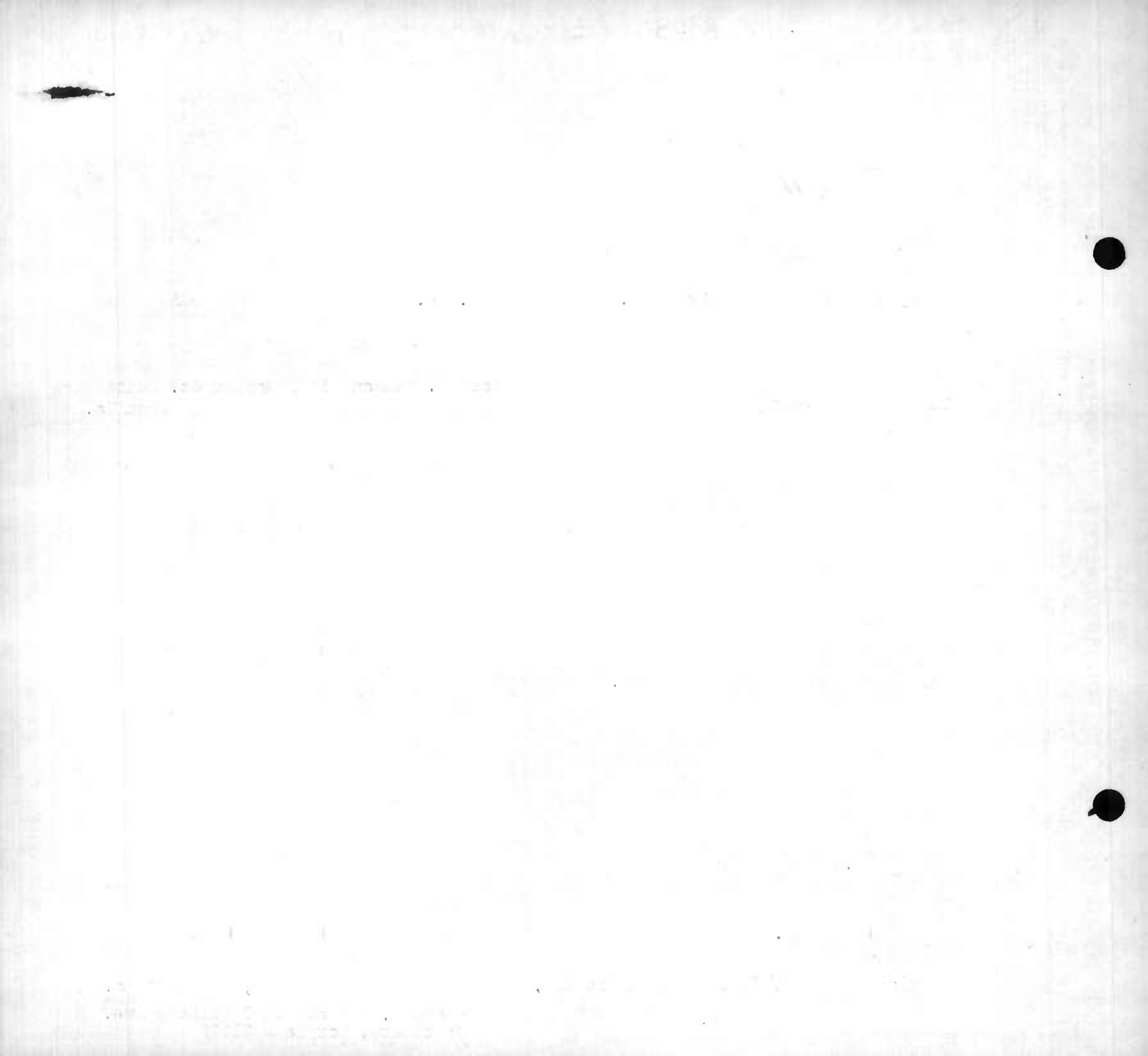
BIRTH NO. 65 8407		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8407	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) DOROTHY WHITE (Mrs. CHARLES)		2. DATE AND HOUR OF DEATH 8-13-65 4:15 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1834 E. JOPPA RD #34			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5/31-21	9. AGE (In years lost birthday) 44 yrs.	10. CITIZEN OF WHAT COUNTRY If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO. MD.	
13. FATHER'S NAME MILTON HERBY DAVIDSON		14. MOTHER'S MAIDEN NAME THERESA KREBS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-18-7868		17. INFORMANT Charles Bert White-1834 E. Joppa Rd	
18. 199.21 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Metastatic Carcinoma DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH One	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from AUG. 6 1965 to AUG. 13 19 65, that (I) (we) last saw the deceased alive on AUG. 13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Brian H. Gross		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/13/65	
23C. PHYSICIAN'S NAME (Type) Brian H Gross		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-16-65		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION Balto. Md.		24E. FUNERAL DIRECTOR John C. Miller Inc. - 6415 Belair Rd.			
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		25B. NAME OF REGISTRAR John C. Miller		25C. ADDRESS 6415 Belair Rd.	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8408	
BIRTH NO. 65 8408		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CARL FRANKLIN DUNCAN		2. DATE AND HOUR OF DEATH 8/13/65 2:25 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		(If not in hospital or institution, give street address or location)		A. STATE West Virginia B. COUNTY Huntington	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Huntington 4 W-45		D. STREET ADDRESS (If rural, give location) 1751- Monroe St.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) N	8. DATE OF BIRTH 6-5-18	9. AGE (In years lost birthday) 47	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shop Foreman		10B. KIND OF BUSINESS OR INDUSTRY Glass Co.		11. BIRTHPLACE (State or foreign country) W. Va.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph Duncan			14. MOTHER'S MAIDEN NAME Carrie Heater		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes ww11		16. SOCIAL SECURITY NO.		17. INFORMANT Carl W. Duncan 1829 Napier St. Huntington West Va.	
18. 411X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ACUTE RENAL TUBULAR NECROSIS DUE TO 16 DA.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) AORTIC INSUFFICIENCY (RHEUMATIC) DUE TO 13 YES.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 3/28/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED AORTIC INSUFFICIENCY		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/13 19 65 to 19 to 19 , that (I) (we) last saw the deceased alive on 8/13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard P. Anderson, M.D.				23B. DATE SIGNED 8/13/65	
23C. PHYSICIAN'S NAME (Type) RICHARD P. ANDERSON		23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/17/65	24C. NAME of CEMETERY or CREMATORY Woodmere Cem.		24D. LOCATION (City, town, or county) (State) Huntington, West Va.	
25A. DATE RECD BY HEALTH DEPT. AUG 16 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard 4107 Wilkens Ave. Baltimore, Maryland 21229	



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 8409				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8409	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				John T. Ryan		August 10, 1965 3 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Maryland		B. COUNTY	
39 Oaklee Village				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
				D. STREET ADDRESS (If rural, give location)		39 Oaklee Village	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
Male	White	WIDOWED, DIVORCED (specify) Widowed	December 10, 1890	74			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Retired Wire Chief			C & P		Baltimore, Maryland		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Timothy Ryan				Rosanna Higgins			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		212-05-0439		William Leo Ryan, 3310 Northway Dr. 21234 Md.			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) <i>Ac. coronary occlusion</i> sudden			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(B) <i>Arteriosclerotic disease</i>			
ANTECEDENT CAUSES				(C)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<i>Ac. Respir. infection</i>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan. 1956 to Aug. 1965, that (I) (we) last saw the deceased alive on Aug. 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
<i>Justin Kudirka</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				8.13.65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. Justin Kudirka				2151 Wilkens Avenue, Balto., Md. 21223			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/14/65		Loudon Park Cemetery		3801 Frederick Ave. Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 16 1965		Robert E. Taylor		Howard H. Hubbard		4107 Wilkens Ave. 21229	

1890

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65 8410

BALTIMORE CITY HEALTH DEPARTMENT

65 8410

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JACOB L. PIPER

2. DATE AND HOUR PRONOUNCED DEAD

8-10-65

4:40 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

SINAI HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3900 Fernhill Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

77

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Bricklayer

10B. KIND OF BUSINESS OR INDUSTRY

Building

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
218-01-8009

17. INFORMANT

ADDRESS

Mrs. Fanny Piper -- Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Asphyxia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Hanging
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Garage

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Rear of 3900 Fernhill Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8 10 '65 3:20

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Hanged self from rafter in garage

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-11-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

8/12/65

23C. NAME OF CEMETERY or CREMATORY

Mikro Kodesh Beth Israel

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 16 1965

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

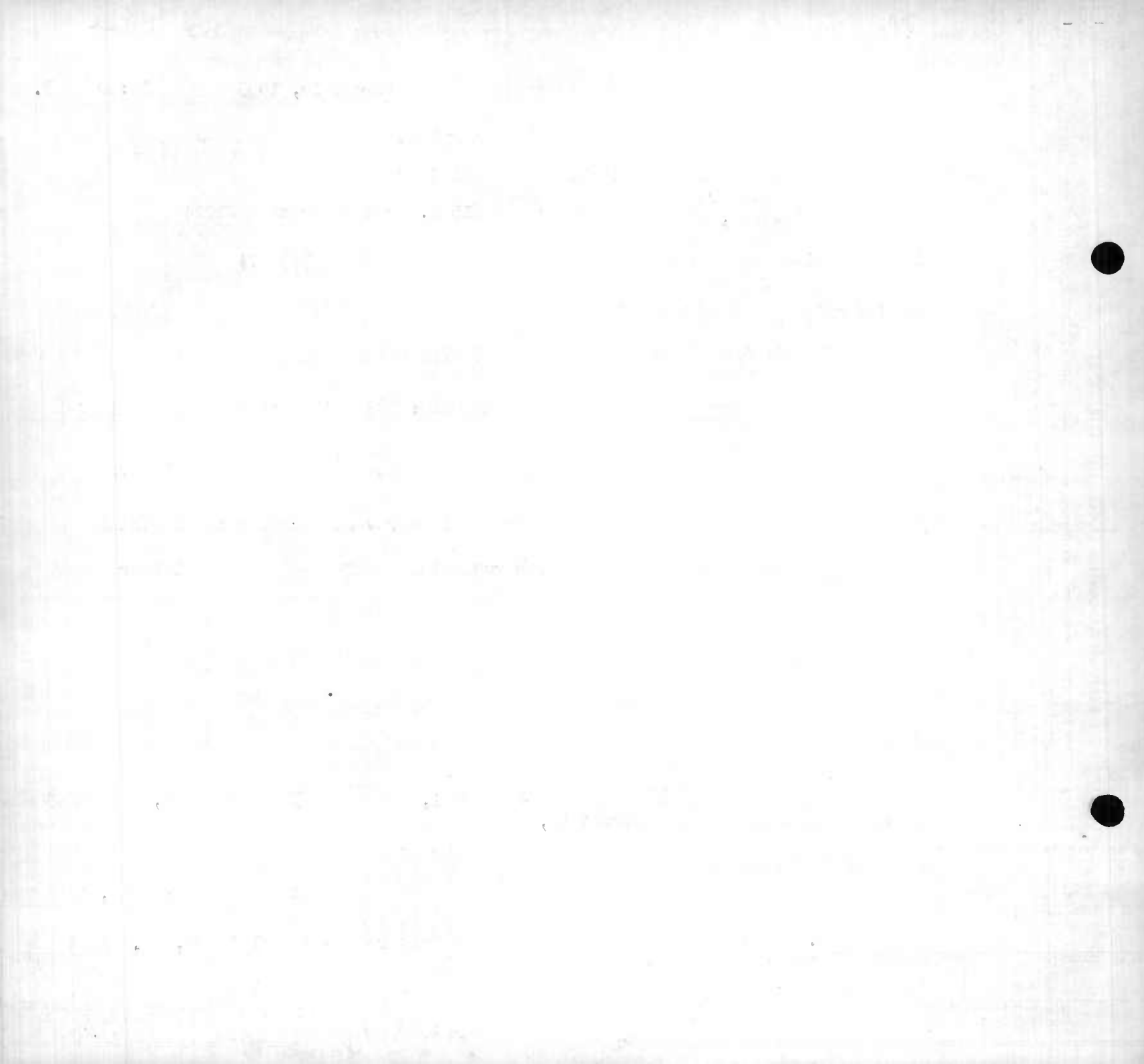
SOL LEVINSON & BROS. INC. 6010 Reist Rd.

ADDRESS

VALLEY FOUNTAIN

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8411	
BIRTH NO. <u>326 65 8411</u>				CERTIFICATE OF DEATH	
M.E. CASE NO.				1. NAME OF DECEASED	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
Frank Metzger (BENJAMIN F. METZGER)				August 10, 1965 12:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location)				615 S. Grundy Street 21224	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
Male		White		MARRIED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
RETIRED		BLACKSMITH		JAN. 12, 1894	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		9. AGE (In years last birthday)	
BALTIMORE, MD.		U. S. A.		(71) 71	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
AUGUST H. METZGER				CHRISTINE WIENECKE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
NO				212-07-9845	
17. INFORMANT				ADDRESS	
RECORDS: BCH 4940 Eastern Avenue				21224	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				5 Days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				6 Months	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				1 Year	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 1, 19 65 to August 10, 19 65, that (I) (we) last saw the deceased alive on August 10, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. Howard Rathbun				August 10, 1965	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Howard Rathbun				4940 Eastern Avenue Baltimore, Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		8-13-65		OAK LAWN CEM.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 16 1965		Robert E. Farkner		Charles J. Feiler	
24D. LOCATION (City, town, or county) (State)		24E. LOCATION (City, town, or county) (State)		24F. LOCATION (City, town, or county) (State)	
7225 EASTERN BLVD. BALTO., CO., MD.		7225 EASTERN BLVD. BALTO., CO., MD.		7225 EASTERN BLVD. BALTO., CO., MD.	



BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED
(Type or Print)

MARY L. BOBLITZ

2. DATE AND HOUR PRONOUNCED DEAD

8/9/65 12:45 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1728 W. BALTIMORE ST.

5. SEX

6. RACE

female white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
SEPARATED

8. DATE OF BIRTH

MAR. 22, 1929

9. AGE (In years
last birthday)

(36) 36

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SORTER

10B. KIND OF BUSINESS OR INDUSTRY

PHILCO BAG CO.

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD.

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

FRANK BACH

14. MOTHER'S MAIDEN NAME

ROSE BECKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

213-26-472

17. INFORMANT

Frances J. Bach

ADDRESS

5 BLADEN RD. BALTO., 21, MD.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Septicemia associated with endometritis
DUE TO

following delivery of a macerated fetus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/10/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

8-13-65

23C. NAME of CEMETERY or CREMATORY

BALTIMORE NATIONAL CEM.

23D. LOCATION

(City, town, or county)

(State)

5501 FREDERICK AVE, BALTO., MD.

24A. DATE REC'D BY HEALTH DEPT.

AUG 16 1965

24B. NAME OF REGISTRAR

Robert E. Faller, M.D.

24C. FUNERAL DIRECTOR

Charles L. Faller

ADDRESS

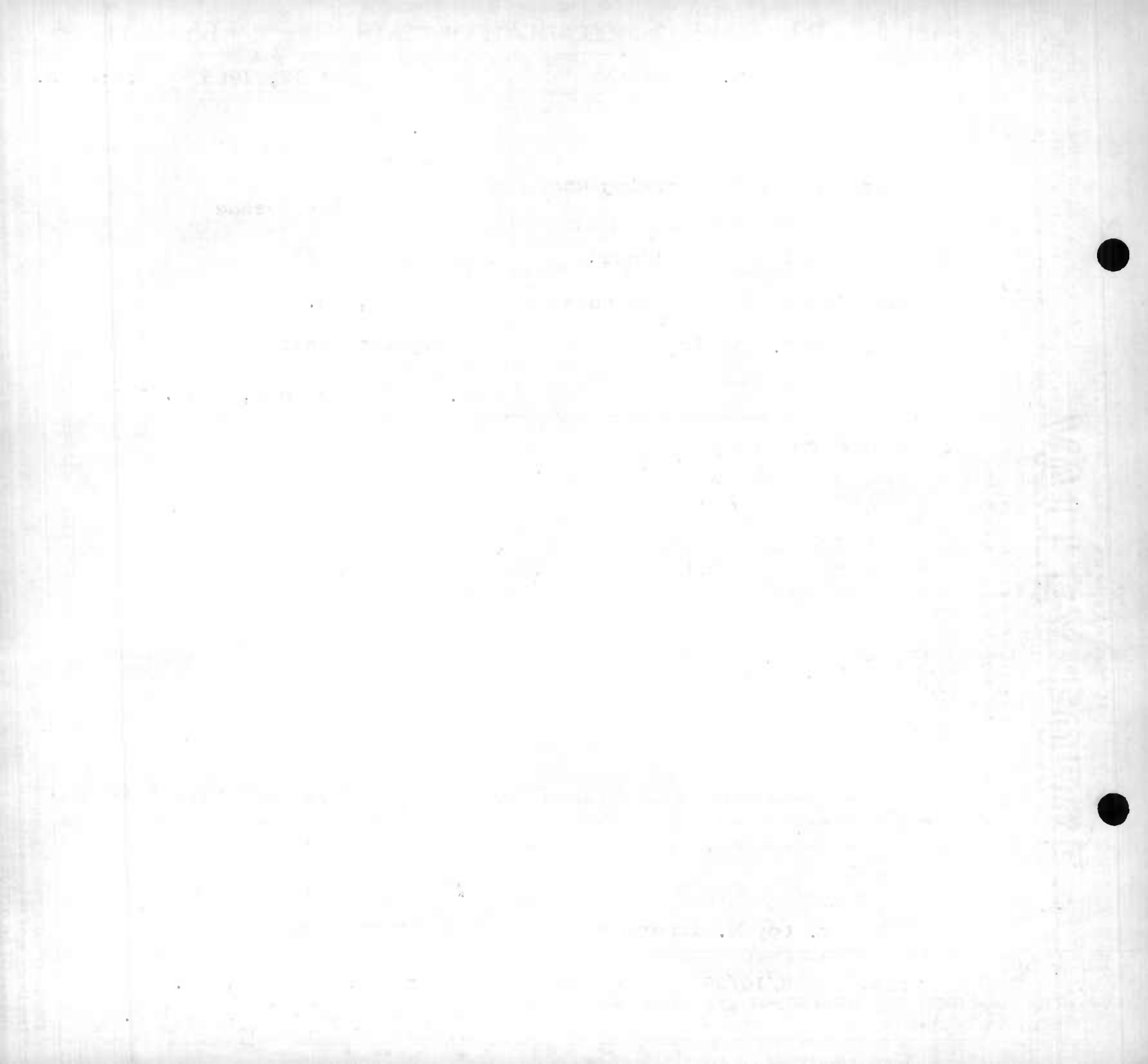
901 S. CONKLING ST.
BALTO., 21224, MD.

8/17/65 - Cesarean Section 8/17/65 -
Information was taken from
Dr. Thomas Huff - J.H.H. Jr

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

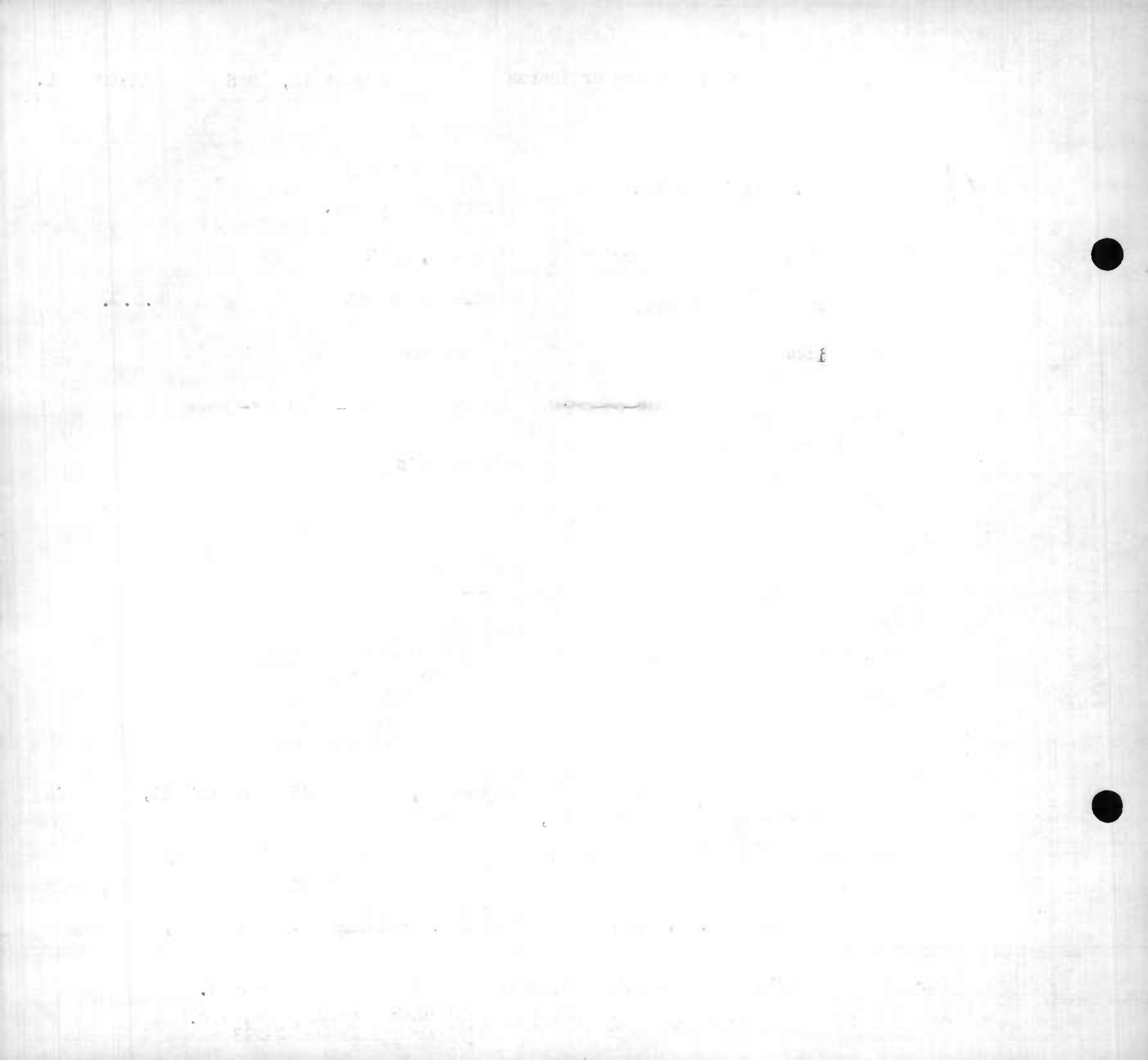
BIRTH NO. 65 8413		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8413	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JANE C. SULLIVAN		2. DATE AND HOUR OF DEATH August 12, 1965 10:30 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harford Gardens Nursing Home		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. 21213 B. COUNTY 26-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3416 Dudley Avenue			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 3/6/1888	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME James T. Manning		14. MOTHER'S MAIDEN NAME Margaret Maher	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Doris Neubauer, dght. above	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Pneumonia DUE TO (B) Atherosclerotic Cardio-Vascular Disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 5 days Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 31 1965 to August 12 1965, that (I) (we) last saw the deceased alive on August 11 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Loy M. Zimmerman		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/13/65	
23C. PHYSICIAN'S NAME (Type) Dr. Loy M. Zimmerman		23D. ADDRESS 3202 Harford Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/65		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965			
25B. NAME OF FUNERAL HOME Schimunek Funeral Home, Inc.		25C. FUNERAL DIRECTOR 3331 Brehms Lane			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		65 8414		65 8414	
CERTIFICATE OF DEATH					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		Jackson, Theresa or Therza		2. DATE AND HOUR OF DEATH August 13, 1965 11:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital		A. STATE Maryland B. COUNTY 26-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21213 D. STREET ADDRESS (If rural, give location) 3827 Elmley Ave.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 9, 1902	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Czechoslovakia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown Picka		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Harry Jackson - husband-above	
18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Carcinomatosis DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 11, 19 65, to August 13, 19 65, that (I) (we) last saw the deceased alive on August 13, 19 65, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alphonso Y. S. Rhee				23B. DATE SIGNED August 13, 1965	
23C. PHYSICIAN'S NAME (Type) Alphonso Y. S. Rhee				23D. ADDRESS 1400 N. Caroline St., Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/65		24C. NAME OF CEMETERY or CREMATORY Bohemian National Cemetery	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. AUG 16 1965			
24F. NAME OF REGISTRAR Robert E. Jackson		24G. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		24H. ADDRESS 3331 Brehms Lane 21213	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8415		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 8415	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) KATHERINE C. GUNTHER			2. DATE AND HOUR OF DEATH August 11, 1965 9:30 p. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 822 S. Clinton Street Baltimore, Md., 22124 9-9-65			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 26-11 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 822 S. Clinton Street		
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 11/6/85 1879	9. AGE (In years lost birthday) 85	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Philip Freund			14. MOTHER'S MAIDEN NAME Caroline?Emrich		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Phila. Rd. & Ravenwood Ave., Mrs. Edna M. Wallis, Zone 6		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Generalized arterio sclerosis. (B) arterio sclerotic heart disease. (C) anemia.		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)	(Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (the hospital) attended the deceased from 6/21 1952 to 8/11 1965. that (I) (we) last saw the deceased alive on 8/9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE E. A. Flanigan Jr.			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED 8/12/65	
23C. PHYSICIAN'S NAME (Type) Dr. Edward A. Flanigan, M.D.			23D. ADDRESS 3501 Fait Avenue		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/14/65	24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965	25B. NAME OF REGISTRAR Robert E. Farley	25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane			

Birth Cert. A-34871 - 1879 and letter from
Doctor for Item 22 M.H. 9-9-65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8416				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8416	
M.E. CASE NO.				8 p.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
MARY M. MEINZINGER				August 11, 1965			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Johns Hopkins Hospital				Md., 21205			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				3318 McElderry Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
female	white	widowed	Dec. 11, 1892	72			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
housewife		at home		Baltimore, Md.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Kiessling				Louise Streb			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
				Bernard L. Meinzinger, son, above			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)				(A) Acute Cardiovascular decompensation		12 hrs	
ANTECEDENT CAUSES				(B) Diabetes Mellitus + major complications		7 yrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)		26 + yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 19 18 to Aug 11 19 65, that (I) (we) last saw the deceased alive on Aug 11 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Dr. Israel J. Feinglos						8/12/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. Israel J. Feinglos				2002 E. Pratt Street			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/16/65		Baltimore National Cem.		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 16 1965		Robert E. Feinglos		Schimunek Funeral Home, Inc.		72601 E. Madison Street	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

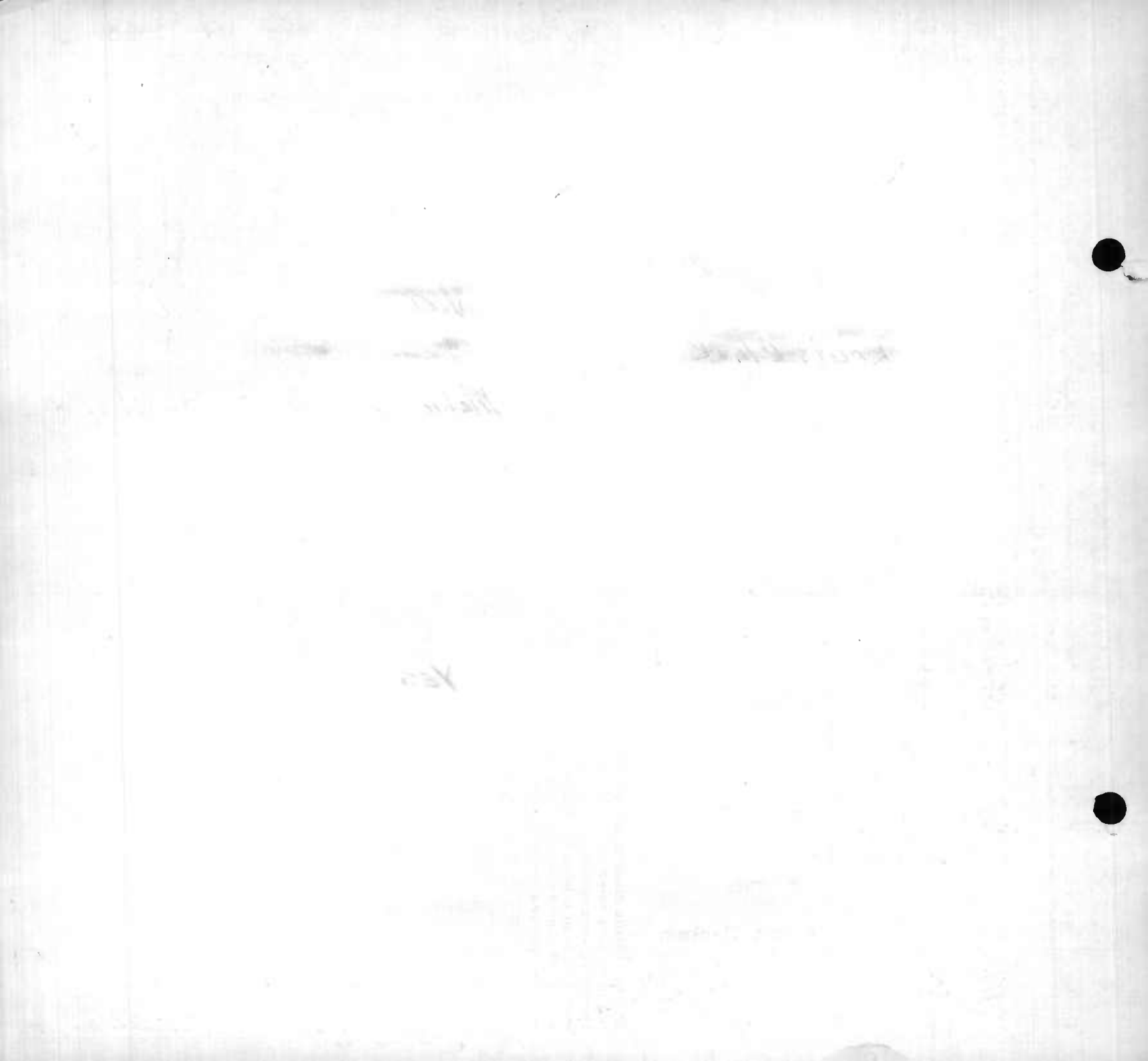
BIRTH NO. 65 8417		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8417	
1. NAME OF DECEASED (Type or Print) Victoria Clark			2. DATE AND HOUR OF DEATH 8/13 17:00 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1152 Stricker Street		
5. SEX Female			6. RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH DATE 12/25/02 AGE (In years, months, days) 62
13. FATHER'S NAME Benjamin Green			14. MOTHER'S MAIDEN NAME Ingenia Rich		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT INEZ Jackson 1853 W. North Ave.
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO Intra Cranial Bleed (B) DUE TO (C) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 19 days
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertensive Cardiovascular disease					
19A. DATE OF OPERATION 10		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/12/65 to 8/13/65 , that (I) (we) last saw the deceased alive on 8/13/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Jonathan Tuerk				23B. DATE SIGNED 8/13/65	
23C. PHYSICIAN'S NAME (Type) Jonathan Tuerk				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/17/65		24C. NAME OF CEMETERY or CREMATORY Church Cem.	
24D. LOCATION (City, town, or county) (State) Sumter, S. C.		25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Henry H. Kellon 1348 N. Calhoun St			

vs 153 by funeral director & Baptismal certificate of registrant.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8418				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8418	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Malcolm Clark</i>			
2. DATE AND HOUR OF DEATH <i>8/12/65 - 2:17 P.M.</i>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>46 Lutheran Hospital</i>				A. STATE <i>MD.</i> B. COUNTY <i>15-06</i>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location) <i>1708 - Braddish Ave.</i>			
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>NEVER MARRIED</i>	8. DATE OF BIRTH <i>9/22/08</i>	9. AGE (In years lost birthday) <i>56</i>	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Louis Clark</i>				14. MOTHER'S MAIDEN NAME <i>Mable Jackson</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMATION ADDRESS <i>Mable Jackson 1708 Braddish Ave</i>		
18. <i>331X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES				(A) <i>CVA.</i> DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>Hemorrhage</i> DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C)			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <i>August 12, 1965</i> to <i>August 13, 1965</i> , that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>R. Blackman</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>8/12/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Robert Blackman</i>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/17/65</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt Auburn Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 16 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR <i>George A. Nelson</i>		ADDRESS <i>1348 N. Calhoun St</i>	



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65 8419

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 8419

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) HERBERT HEATH

2. DATE AND HOUR PRONOUNCED DEAD 8.14.65 3:30 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

5. SEX male 6. RACE colored 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single

8. DATE OF BIRTH March 9, 1926 9. AGE (In years last birthday) 39

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 11. BIRTHPLACE (State or foreign country) Hallsboro N.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John K. Heath 14. MOTHER'S MAIDEN NAME Matry Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II 16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Emory Heath-Rt. #1 Box 3-Hallsboro

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2. 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) North Ave. near Ashburton St. 15-06

21D. TIME OF INJURY (APPROX.) 8 14 65 3:00a. 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21F. HOW DID INJURY OCCUR? pedestrian struck by car

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) RUDIGER BREITENECKER, M.D. CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED 8/14/65

ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 8/19/65 23C. NAME of CEMETERY or CREMATORY Mt. Hebron Cemetery 23D. LOCATION (City, town, or county) (State) Hallsboro N.C.

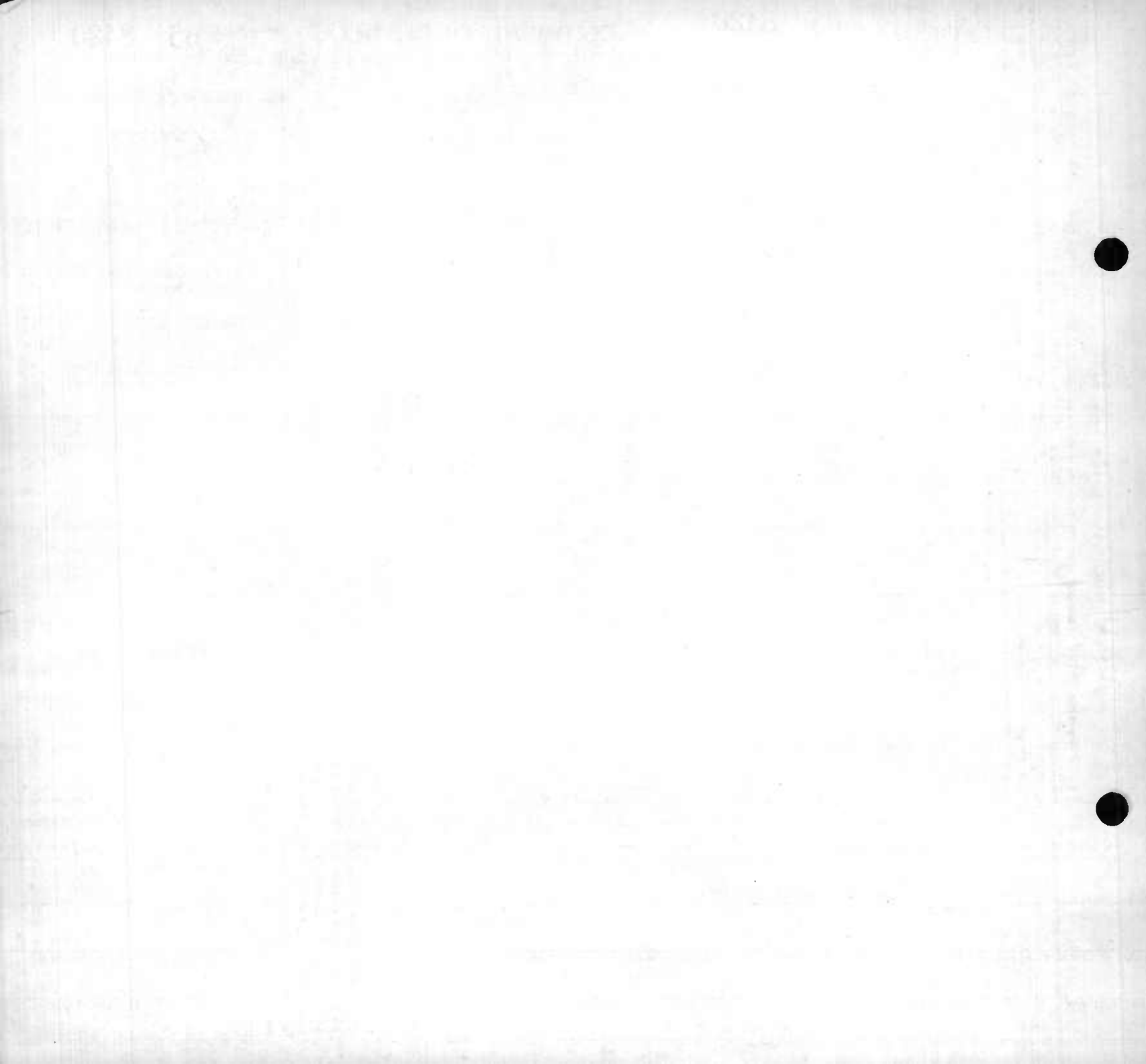
24A. DATE REC'D BY HEALTH DEPT. AUG 16 1965 24B. NAME OF REGISTRAR Robert E. Fathauer 24C. FUNERAL DIRECTOR Herbert E. Nutter-3035 W. North Ave

WALTER D. BROWN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8420		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8420	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HERMAN BARRY LANE		2. DATE AND HOUR OF DEATH AUG. 13, 1965 11:07 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Balto			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto 5300			
		D. STREET ADDRESS (If rural, give location) 4726 Byron Rd			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH April 26 1918	9. AGE (In years lost birthday) 47	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales manager		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Jacob		14. MOTHER'S MAIDEN NAME Geline			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 074-2-0007		17. INFORMANT Blanche Lane	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CERTIFICATION APPROVED BY <i>[Signature]</i> CHIEF OF BUREAU OF MEDICAL EXAMINERS		CAUSE OF DEATH Post. Ac. Myocardial Infarction ASHD INTERVAL BETWEEN ONSET AND DEATH 5+ yrs.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i> DANIEL BAKAL				23B. DATE SIGNED 8.14.65	
23C. PHYSICIAN'S NAME (Type) DANIEL BAKAL				23D. ADDRESS M.D. 3600 Lochearn Dr Balto, Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/15/65		24C. NAME OF CEMETERY OR CREMATORY Rosedale	
24D. LOCATION Balto,		24E. LOCATION (City, town, or county) (State) Md			
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Sylvan S. Lewis & Son ADDRESS 3319 Olympia Ave	



BIRTH NO. 65 8421 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 8421

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HAYWOOD KNOTTS

2. DATE AND HOUR PRONOUNCED DEAD

8/7/65 12:05 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1511 N. Washington St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

10-21-1919

9. AGE (in years
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Steel Co.

11. BIRTHPLACE (State or foreign country)

Wadestown, N.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Paul Knotts

14. MOTHER'S MAIDEN NAME

Phenie Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

218-09-7226

17. INFORMANT

Margie MacKnotts 17254 Montford Ave.

ADDRESS

18. 5-8-1-1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Acute ethylism
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Fatty liver

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/8/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

8-13-65

23C. NAME of CEMETERY or CREMATORY

Williams Cemetery

23D. LOCATION

(City, town, or county)

(State)

Wadestown, N.C.

24A. DATE REC'D BY HEALTH DEPT.

AUG 16 1965

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

Ralph J. Collick 1412 E. Preston St.

ADDRESS

WILLIAM B. F. (1914)

BIRTH NO. 65 8422 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 8422

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)BESSIE (NEE BEALE)
WATSON KELLER

2. DATE AND HOUR PRONOUNCED DEAD

August 12, 1965 2:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

343 Presstman Street

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

343 Presstman Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widow

8. DATE OF BIRTH

12-22-1904

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Watson Beale

14. MOTHER'S MAIDEN NAME

Lillian Holland

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

220-30-1070

17. INFORMANT

ADDRESS

Mary Dunlap - 2213 Madison Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORKNOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/12/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-16-65

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

AUG 16 1965

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Charles R. Law 802 Madison Ave.

ADDRESS

WALLER & SONS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 8423		CERTIFICATE OF DEATH		Registered No. 65 8423	
1. NAME OF DECEASED (Type or Print) EPPS, RUSSELL LEE				2. DATE AND HOUR OF DEATH 8-13-1965 A. <small>M.</small>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE Maryland B. COUNTY 15-09					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 7 MERCY HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					
				D. STREET ADDRESS (If rural, give location) 2312 Chelsea Terrace					
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH July 17, 1911		9. AGE (In years last birthday) 54		If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10B. KIND OF BUSINESS OR INDUSTRY Munsey Bldg.		11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Epps			14. MOTHER'S MAIDEN NAME Ollie						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Ellen Epps, 2312 Chelsea Terrace				
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral infection DUE TO Cerebrovascular thrombosis with hemorrhage. DUE TO Hypertensive Cardiovascular Disease				INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 8-12 1965 to 8-13 1965 , that (I) (we) last saw the deceased alive on 8-13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE Joseph Notarangelo M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED 8-13-1965			
23C. PHYSICIAN'S NAME (Type) JOSEPH NOTARANGELO M.D.						23D. ADDRESS MERCY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-17-65		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Charles R. Law Mortuary, 802 Madison Ave.					

65 8424

BALTIMORE CITY HEALTH DEPARTMENT

65 8424

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LOUIS EDWARD POLLARD

2. DATE AND HOUR PRONOUNCED DEAD

August 11, 1965

11:10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Bon Secour Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1317 W. Fayette Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Aug. 14, 1941

9. AGE (In years
last birthday)

23

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Chesterfield Co., Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert Pollard

14. MOTHER'S MAIDEN NAME

Marie Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Marie J. Pollard - 123 E 20th, Richmond, Va.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Stab Wound of Chest.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

House

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

1952 W. Pratt Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8 11 '65 P

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Stabbed in chest.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/12/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8-16-65

23C. NAME of CEMETERY or CREMATORY

Chesterfield

23D. LOCATION

(City, town, or county)

(State)

Chesterfield Co., Virginia

24A. DATE REC'D BY HEALTH DEPT.

AUG 16 1965

24B. NAME OF REGISTRAR

Robert E. Petty

24C. FUNERAL DIRECTOR

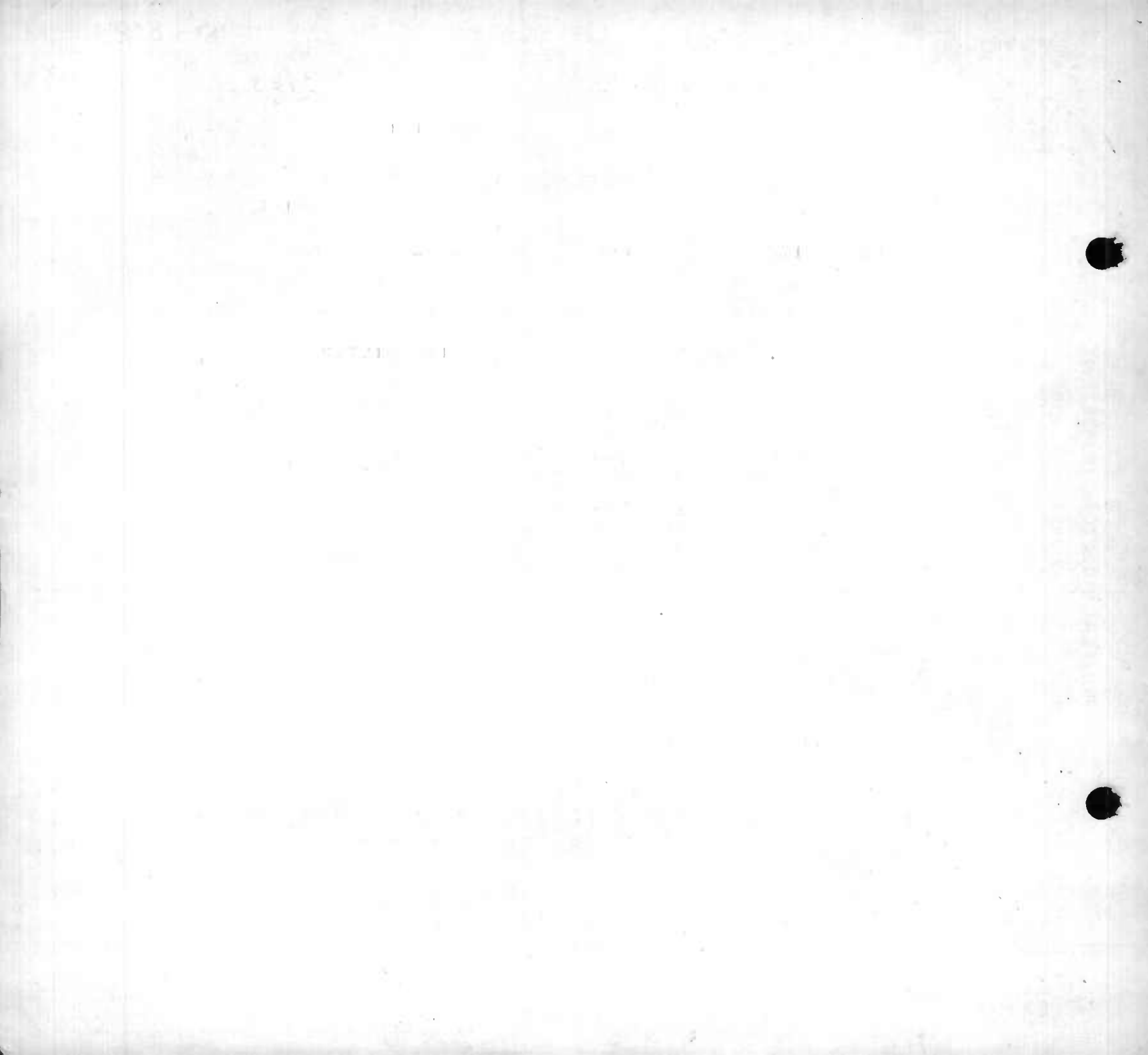
Mims F. H. - Richmond, Va.

ADDRESS

WALLPAPER FORCE

Released on approval by *Dr. Bratuker M.D.*
FUNERAL DIRECTOR: IMPORTANT
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 8425					CERTIFICATE OF DEATH		Registered No. 65 8425		
1. NAME OF DECEASED (Type or Print) LINDA CALLIS					2. DATE AND HOUR OF DEATH 8/13/65 6 P. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE VIRGINIA B. COUNTY K-43 C. CITY OR TOWN (If outside city limits, write RURAL and give township) NEWPORT NEWS D. STREET ADDRESS (If rural, give location) 1251 GARDEN DRIVE				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSP									
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 6-22-46	9. AGE (In years lost birthday) 19	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11. BIRTHPLACE (State or foreign country) New Port News, VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ANDERSON K. FARBER				14. MOTHER'S MAIDEN NAME EDITH HILTON					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mr. GARY CALLIS 1251 Garden Dr. Newport News, Va.			
18. 754.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.) TETRALOGY OF FALLOT ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. POLYCYTHEMIA				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 19 YRS.			
19A. DATE OF OPERATION 8/13/65				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARDIAC MASSAGE		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) this hospital attended the deceased from 8/11 19 65 to 8/13 19 65 , that (1) we lost saw the deceased alive on 8/13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE J. R. SPENCER						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/13/65	
23C. PHYSICIAN'S NAME (Type) J. R. SPENCER						23D. ADDRESS JOHNS HOPKINS HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/16/65		24C. NAME OF CEMETERY or CREMATORY PENINSULA MEM. PARK		24D. LOCATION (City, town, or county) (State) NEWPORT NEWS, VA.			
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Wm. J. Jackson & Sons		ADDRESS North & Pa. Aves.			



BIRTH NO. 65 8426		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8426	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) SAMUEL G. SMITH			2. DATE AND HOUR PRONOUNCED DEAD August 13, 1965 10:35 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital			A. STATE Maryland B. COUNTY Howard		
			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Simpsonville 63-00		
			D. STREET ADDRESS (If rural, give location) 15 Wesley Drive		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH July 4, 1900	9. AGE (In years last birthday) 65	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President		10B. KIND OF BUSINESS OR INDUSTRY S. G. Smith Co., Inc Industrial Cleaning		11. BIRTHPLACE (State or foreign country) Russia	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Gerschwin Smith			14. MOTHER'S MAIDEN NAME Bessie		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS same Mrs. Mary Catherine Hooper Smith address		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
Antecedent Causes DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2					
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Store		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2525 N. Calvert Street 12-03	
21D. TIME OF INJURY (APPROX.) 8 13 '65 A		21E. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK []		21F. HOW DID INJURY OCCUR? Fell down stairs.	
22. I certify that I held an Inquiry [] Inspection [] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [] Accident [X] Suicide [] Homicide [] Undetermined manner []					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D.		M.D. ASSISTANT MEDICAL EXAMINER [X]		ASSOCIATE MEDICAL EXAMINER []	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 8/16/1965	23C. NAME of CEMETERY or CREMATORY Arlington Cemetery		23D. LOCATION (City, town, or county) Baltimore, Maryland
24A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		24B. NAME OF REGISTRAR Robert E. Farber, M.D.		24C. FUNERAL DIRECTOR Wm. F. Tidman & Son Baltimore, Md. 17	

WALTER ROBERT

BIRTH NO.

65

8427

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Elmer MEYER

2. DATE AND HOUR PRONOUNCED DEAD

8/15/65

7

a

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Maryland Gen.Hosp. DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2318 Callow Avenue

17

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Jan. 19, 1906

9. AGE (In years
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Sheet Metal Worker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Illinois

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Philip Meyer

14. MOTHER'S MAIDEN NAME

Emma Lawrenz

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

Yes

World War II

16. SOCIAL
SECURITY NO.

325-03-1540

17. INFORMANT

Mrs. Lillian M. Meyer Baltimore, Md. 17

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) _____
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S R. Breitenecker
NAME (Type)

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/15/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/18/1965

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 16 1965

24B. NAME OF REGISTRAR

Robert E. Talley, M.D.

24C. FUNERAL DIRECTOR

Wm. F. Dickman & Sons

ADDRESS

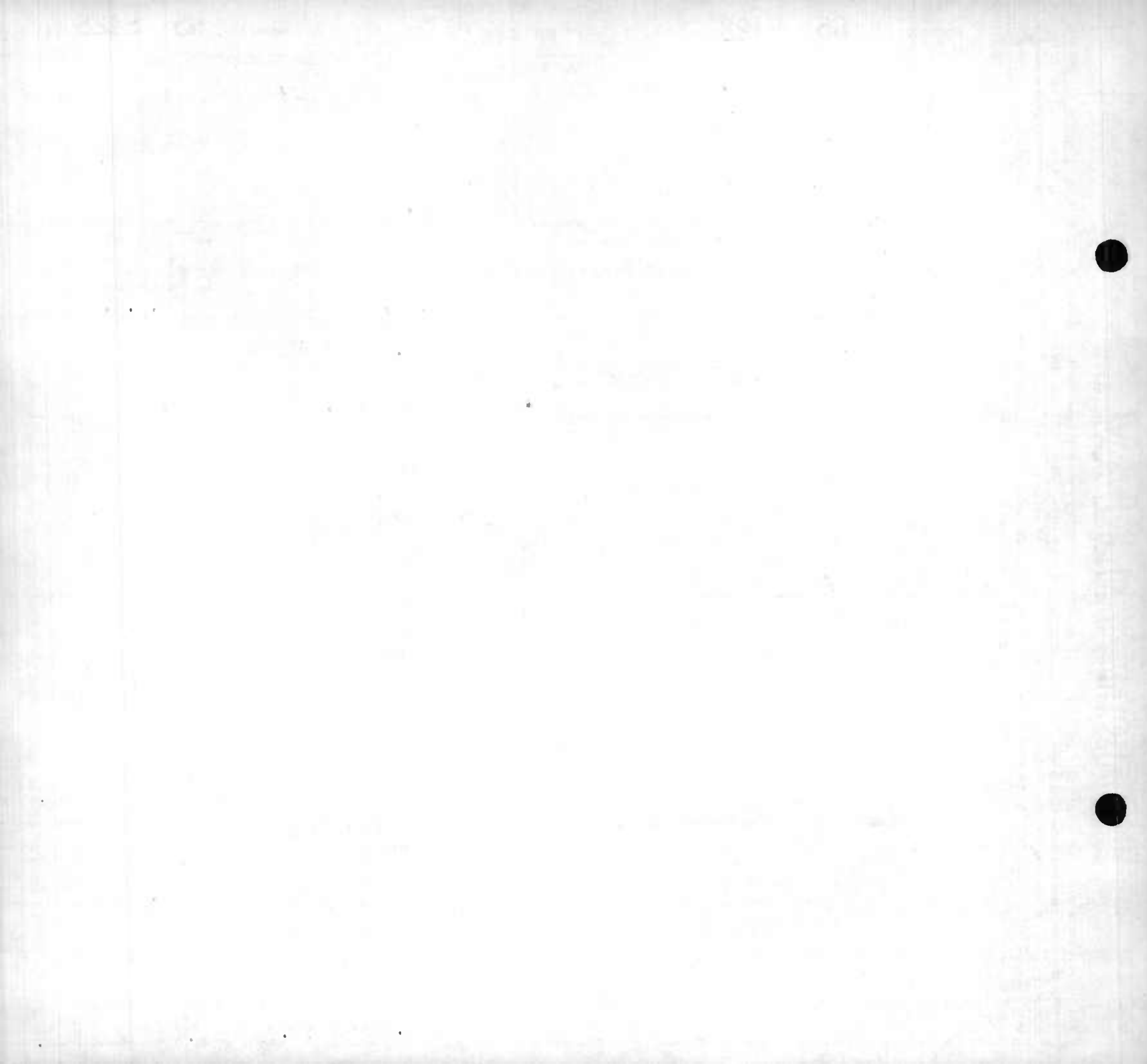
Baltimore, Md. 17
North Ave.

VALLEY FORCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

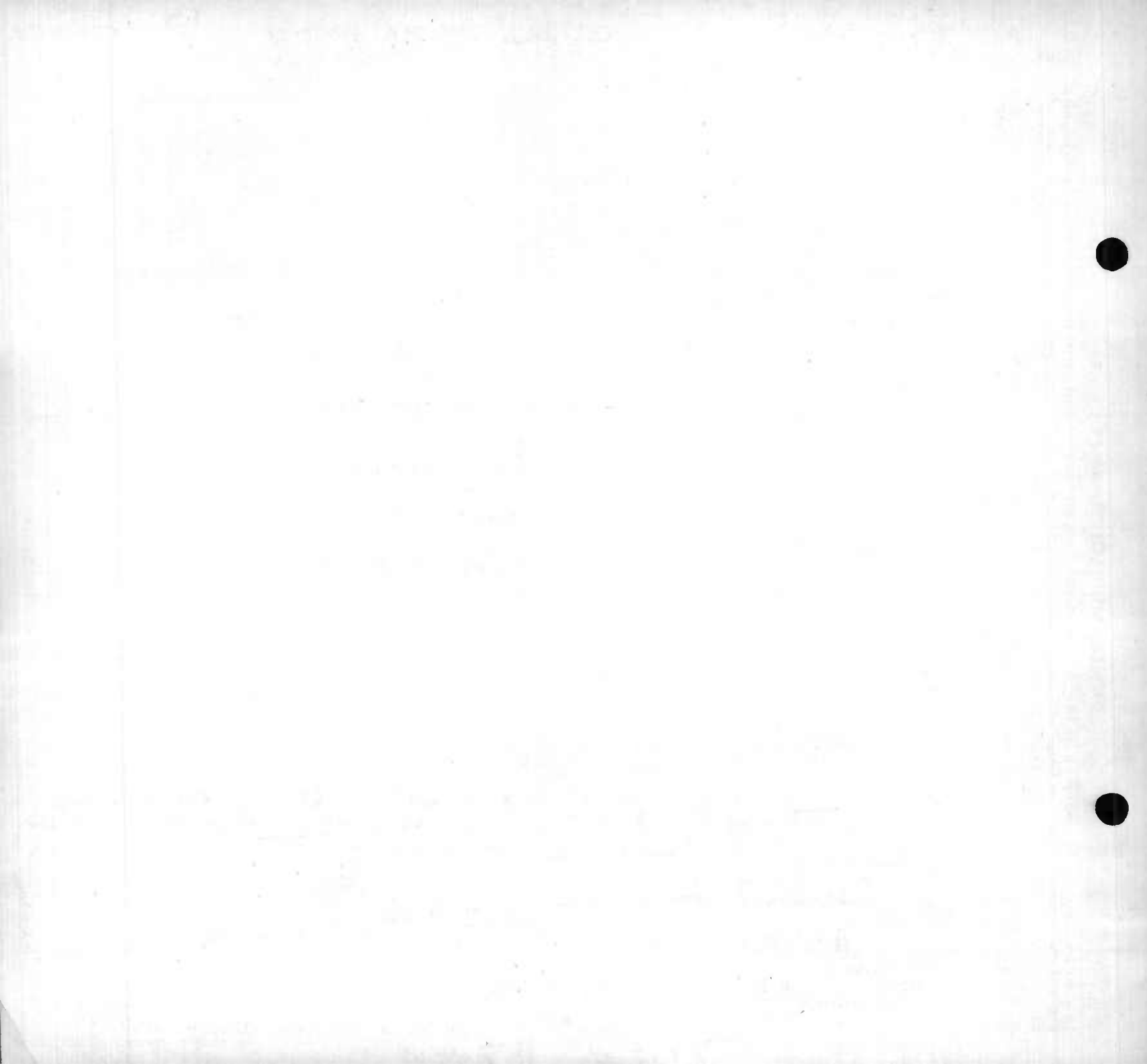
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8428	
BIRTH NO. 65 8428		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mary E. McCahan		2. DATE AND HOUR OF DEATH August 11, 1965 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland B. COUNTY 6-04	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
House in the Pines - Belair 5837 Belair Road		Baltimore		27 N. Ann Street	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 7/10/1878	9. AGE (In years lost birthday) 87	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookbinder		10B. KIND OF BUSINESS OR INDUSTRY Book		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Daniel McCahan		14. MOTHER'S MAIDEN NAME Mary E. McDermott	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT John Farley, Jr. 10 South St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the made at dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Carcinoma Colon (B) DUE TO Liver Metastases (C) DUE TO Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 8 mos. 3 wks.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work [] Not While At Work []		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June-10-1962 to Aug-11-1965, that (I) (we) last saw the deceased alive on Aug-11-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (didn't) view the body after death.					
23A. SIGNATURE Wm G Geyer		M.D. Attending Phys. [] Med. Director [] Staff Phys. []		23B. DATE SIGNED Aug-13-65	
23C. PHYSICIAN'S NAME (Type) WM G GEVER		23D. ADDRESS 156 N. Milton Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/1965		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore, Maryland		24E. STATE			
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR John A. Moran Inc. 3000 E. Baltimore St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. H623 65 8429		CERTIFICATE OF DEATH		Registered No. 65 8429	
1. NAME OF DECEASED (Type or Print) HERMAN HARRISON				2. DATE AND HOUR OF DEATH 8-14-65 1:30 P M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 3-62 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 12 SOUTH EXETER STREET					
5. SEX MALE		6. RACE NEGRO S		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED (SEP)		8. DATE OF BIRTH 4-22-18		9. AGE (In years lost birthday) 47	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME NEDD HARRISON				14. MOTHER'S MAIDEN NAME MARY JANE DOLES					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) No				16. SOCIAL SECURITY NO. 218-07-4716		17. INFORMANT Hospital Chart		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				19. CAUSE OF DEATH (A) Resp. ARREST DUE TO (B) SHOCK, SEPSIS DUE TO (C) BILAT. BRONCHOPNEUMONIA PWR.				INTERVAL BETWEEN ONSET AND DEATH 1 1/2 HR. 6 HR.	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
21A. DATE OF OPERATION 8-11-65		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED LIVER BIOPSY		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		21G. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
22. I certify that (I) (this hospital) attended the deceased from 8-7-65 to 8-14 1965, that (I) (we) lost saw the deceased alive on 8-14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Ashley T. Haase				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) ASHLEY T. HAASE				23D. ADDRESS JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/19/65		24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County Md			
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North AVE			

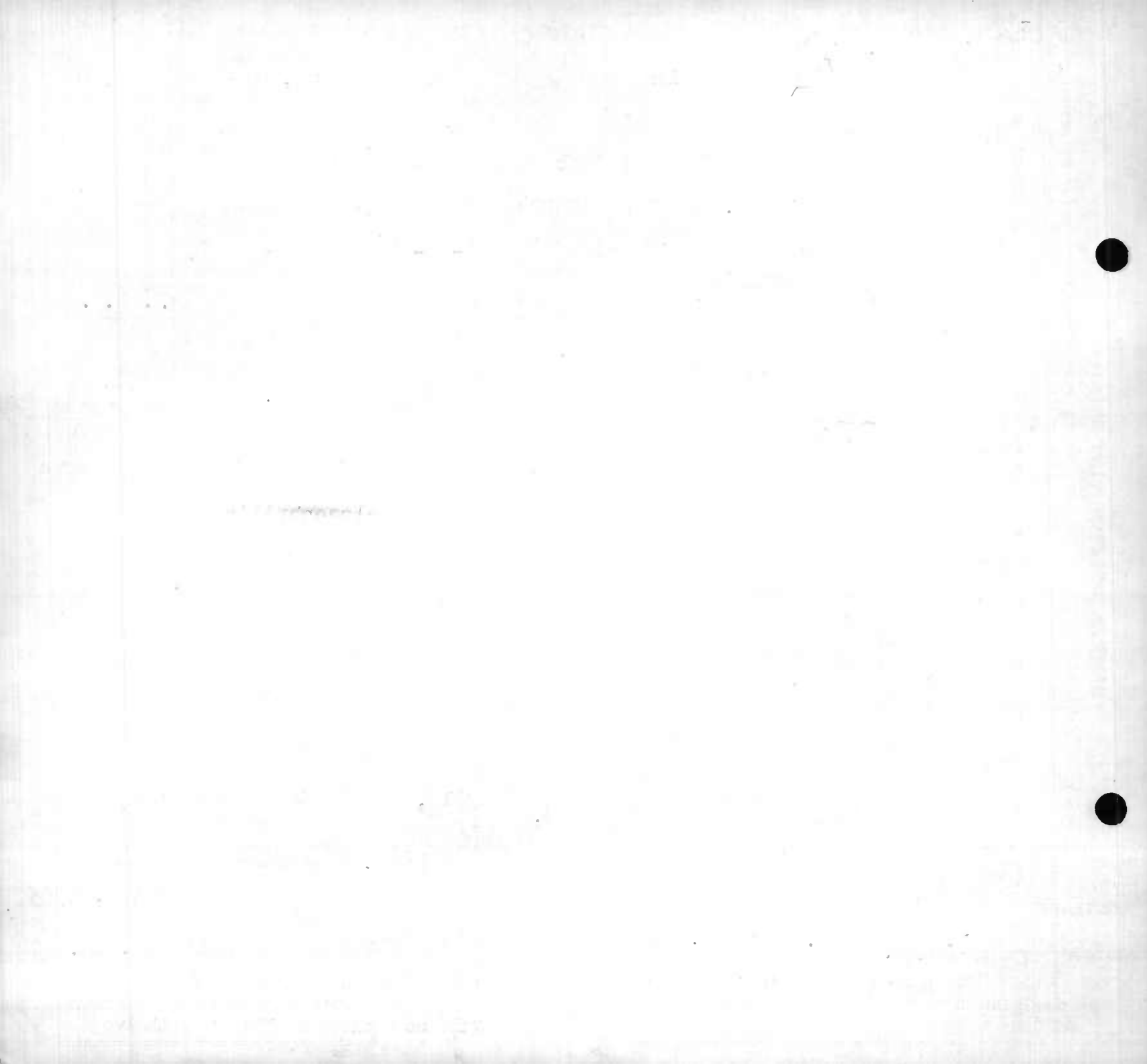


LS: 44-17-96

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B33465 8430		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8430	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED	
				Harry Butler	
2. DATE AND HOUR OF DEATH		August 9, 1965		1:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland		13-04	
Baltimore City Hospital 4940 Eastern Avenue Baltimore, Maryland #21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
D. STREET ADDRESS (If rural, give location)		2816 Parkwood Avenue #21217			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	Negro	Widowed	8-30-73	91	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U. S. A					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				RECORDS: BCH: 4940 Eastern Avenue #24	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(A) DUE TO Gram Negative Septicemia		24 Days	
		(B) DUE TO Acute Pyelonephritis			
		(C) DUE TO Prostatic Carcinoma			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 16, 1965 to August 9, 1965 that (I) (we) last saw the deceased alive on August 9, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Dr. Jeffery Aaronson, M.D.		August 9, 1965			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Jeffery Aaronson		4940 Eastern Avenue Baltimore, Md. #24			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/14/65		Mt Calvary Cemetry	
24D. LOCATION (City, town, or county)		24E. STATE			
A A County Md					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 16 1965		Robert E. Farley, M.D.		Adolphus Halstead 1206 W North Ave	



BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **65 8431**

1
T520

BIRTH NO. **65 8431**

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) GEORGE V. TYNES		2. DATE AND HOUR PRONOUNCED DEAD 8/13/65 10:30 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Provident Hospital		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 1735 McCulloh St.	
5. SEX male	6. RACE colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2/2
9. AGE (In years last birthday) 29		10. Under 1 Yr. If Under 24 Hrs. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Tynes		14. MOTHER'S MAIDEN NAME Berneice	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Ada Tynes		ADDRESS 1735 McCulloh St	
18. CAUSE OF DEATH E982 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Stab wound of chest ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) In front of 1629 Brunt St.			
21D. TIME OF INJURY (APPROX.) 8 13 65 9:58p		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR? stabbed in chest			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) RUDIGER BREITENECKER, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/14/65	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 8/18/65	
23C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery		23D. LOCATION (City, town, or county) (State) A A County Md	
24A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		24B. NAME OF REGISTRAR Robert E. Farley, M.D.	
24C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 9206 W North Ave	

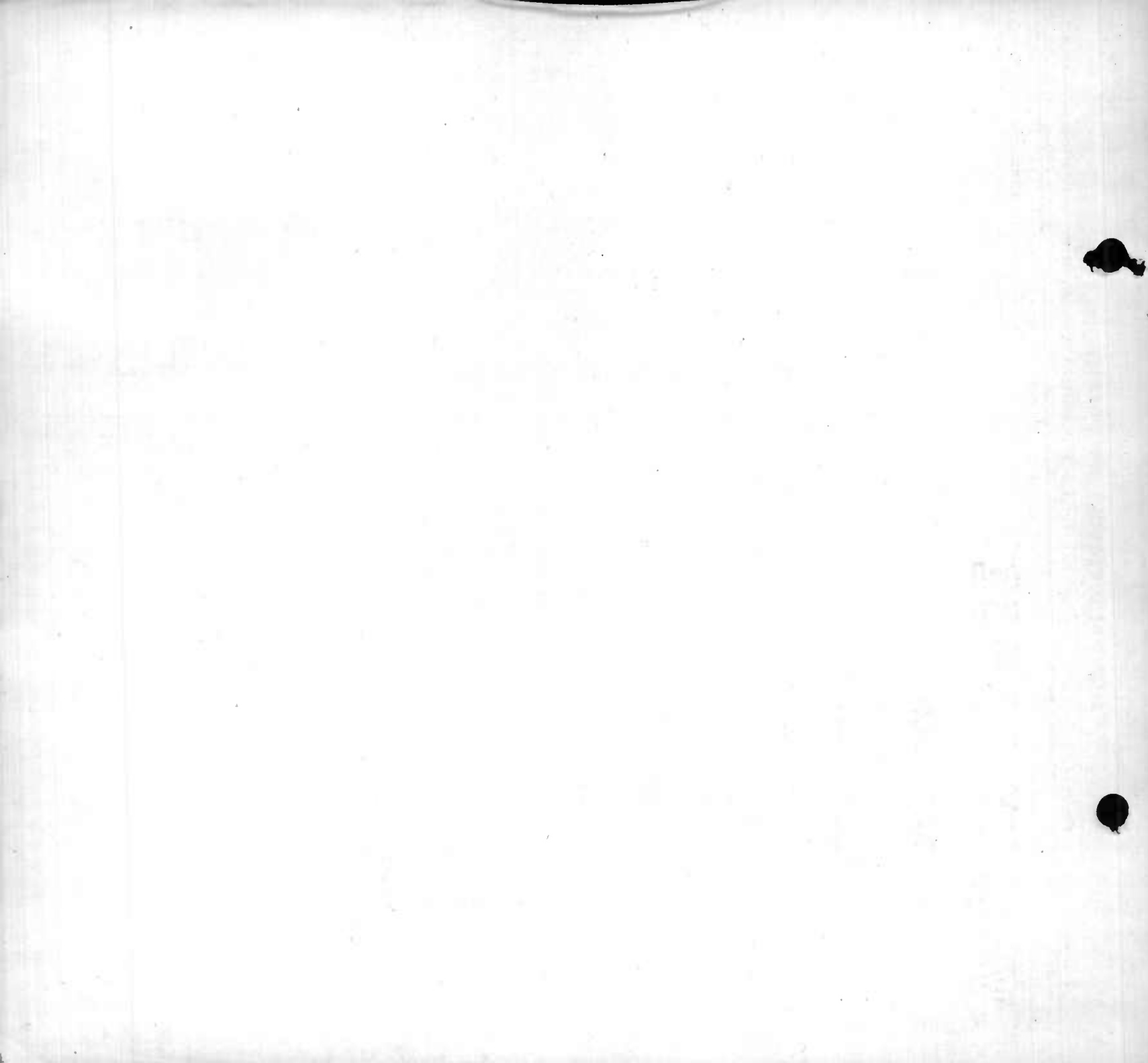
VS 151-REV. 1/1/65

WALLER POND

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

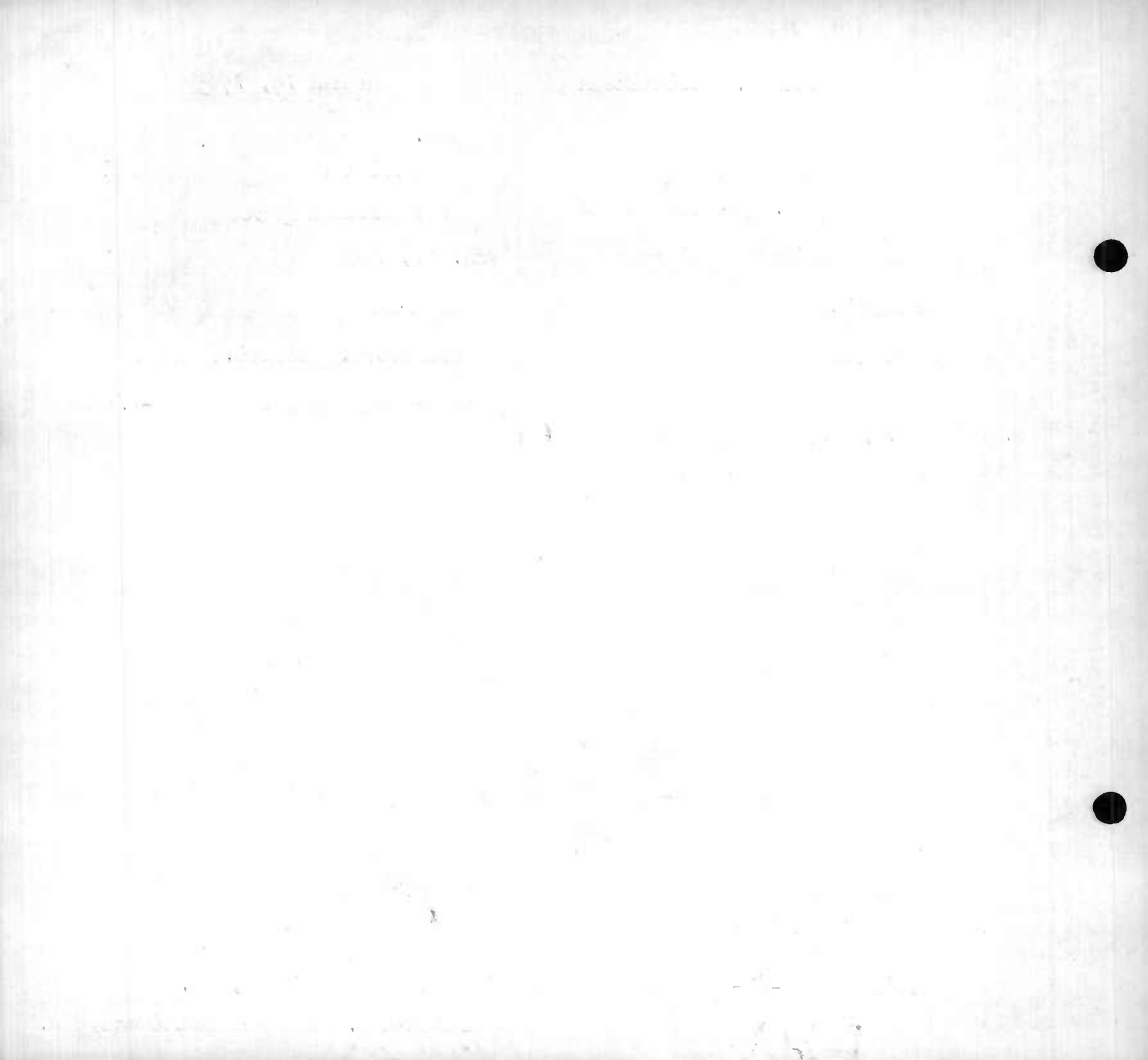
BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 65 8432					CERTIFICATE OF DEATH					Registered No. 65 8432									
1. NAME OF DECEASED (Type or Print) MOHR, MARY ANNE (MAMIE)										2. DATE AND HOUR OF DEATH AUGUST 16 1965 4 A.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL										4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY KINGSVILLE BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) KINGSVILLE 5300 D. STREET ADDRESS (If rural, give location) Mohr Road									
5. SEX F		6. RACE W		7. MARRIED NEVER MARRIED (WIDOWED) DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 12/13/1879		9. AGE (In years lost birthday) 85		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.				10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) IRELAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME CASSIDY THOMAS										14. MOTHER'S MAIDEN NAME TIMLIN MARY									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -				16. SOCIAL SECURITY NO. -		17. INFORMANT				ADDRESS									
18. 5-46-X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Aspiration Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Suodrenal diverticula & bleeding. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. -										CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION 0 -			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -			20A. AUTOPSY? (Yes or No) NO			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?										
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner) -			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)													
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?													
22. I certify that (I) (this hospital) attended the deceased from 8/6 1965 to 8/16 1965, that (I) (we) last saw the deceased alive on 8/15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE B. N. IRANI M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>										23B. DATE SIGNED Aug 16, '65									
23C. PHYSICIAN'S NAME (Type) B. N. IRANI M.D.										23D. ADDRESS UNIVERSITY HOSPITAL									
24A. BURIAL CREMATION, REMOVAL (Specify) 8/19/65			24B. DATE 8/19/65			24C. NAME OF CEMETERY or CREMATORY PARKWOOD Cem			24D. LOCATION (City, town, or county) (State) BALTIMORE Md										
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965			25B. NAME OF REGISTRAR Robert E. Farley M.D.			25C. FUNERAL DIRECTOR Leonard J. Lucke Jr			ADDRESS 5305 Hazford										



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8433	
BIRTH NO. 65 8433		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Lena A. Christensen</i>		2. DATE AND HOUR OF DEATH <i>August 14, 1965</i> <i>2:45 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		5. SEX <i>female</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Melchor Nursing Home</i> <i>2327 N. Charles Street</i>		A. STATE <i>Md.</i> B. COUNTY <i>10X 02</i>		6. RACE <i>white</i>	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i>		8. DATE OF BIRTH <i>Jan. 21, 1880</i>		9. AGE (In years lost birthday) <i>85</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Peter Franz</i>		14. MOTHER'S MAIDEN NAME <i>Not known Catharine Bauch</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mrs Evelyn Hanna 844 Maine-Riviera BCh</i>	
18. I <i>170X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Generalized Carcinomatosis</i> DUE TO (B) <i>Carcinoma of left Breast</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>?</i> <i>?</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7-9-1965</i> to <i>8-14-1965</i> , that (I) (we) last saw the deceased alive on <i>8/4/1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Samuel Legum M.D.</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>8.16-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>SAMUEL LEGUM M.D.</i>		23D. ADDRESS <i>1761 E North Ave Balto. 2 up</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>8-17-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Moreland Memorial Park</i>	
24D. LOCATION <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 16 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck Inc Baltimore, Md.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8434	
BIRTH NO. 65 8434		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ROGER AARON ANTHONY		2. DATE AND HOUR OF DEATH AUG 15, 1965 7:30 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 9-05			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
		D. STREET ADDRESS (If rural, give location) 713 BELLE TERRE AVE.			
5. SEX MALE	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12/11/94	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DISPATCHER		10B. KIND OF BUSINESS OR INDUSTRY SUN CAB CO.		11. BIRTHPLACE (State or foreign country) EASTON, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME RICHARD ANTHONY		14. MOTHER'S MAIDEN NAME ELIZABETH HARRISON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-03-0266		17. INFORMANT ADDRESS 1019 Middlesex Rd. MRS. EVELYN CONKLIN	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.11		CAUSE OF DEATH (A) RESPIRATORY ARREST DUE TO CEREBRAL ANOXIA (B) ACUTE MYOCARDIAL INFARCTION (C) _____		INTERVAL BETWEEN ONSET AND DEATH MINUTES DAYS	
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/12 19 65 to 8/15 19 65 , that (I) (we) last saw the deceased alive on 8/15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE William R. Linton Jr.				23B. DATE SIGNED 8/15/65	
23C. PHYSICIAN'S NAME (Type) WILLIAM R. LINTON JR.				23D. ADDRESS UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/18/65		24C. NAME OF CEMETERY or CREMATORY Oxford Cemetery	
24D. LOCATION (City, town, or county) (State) Oxford, Maryland					
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Buck Inc 5305 Harford Road	

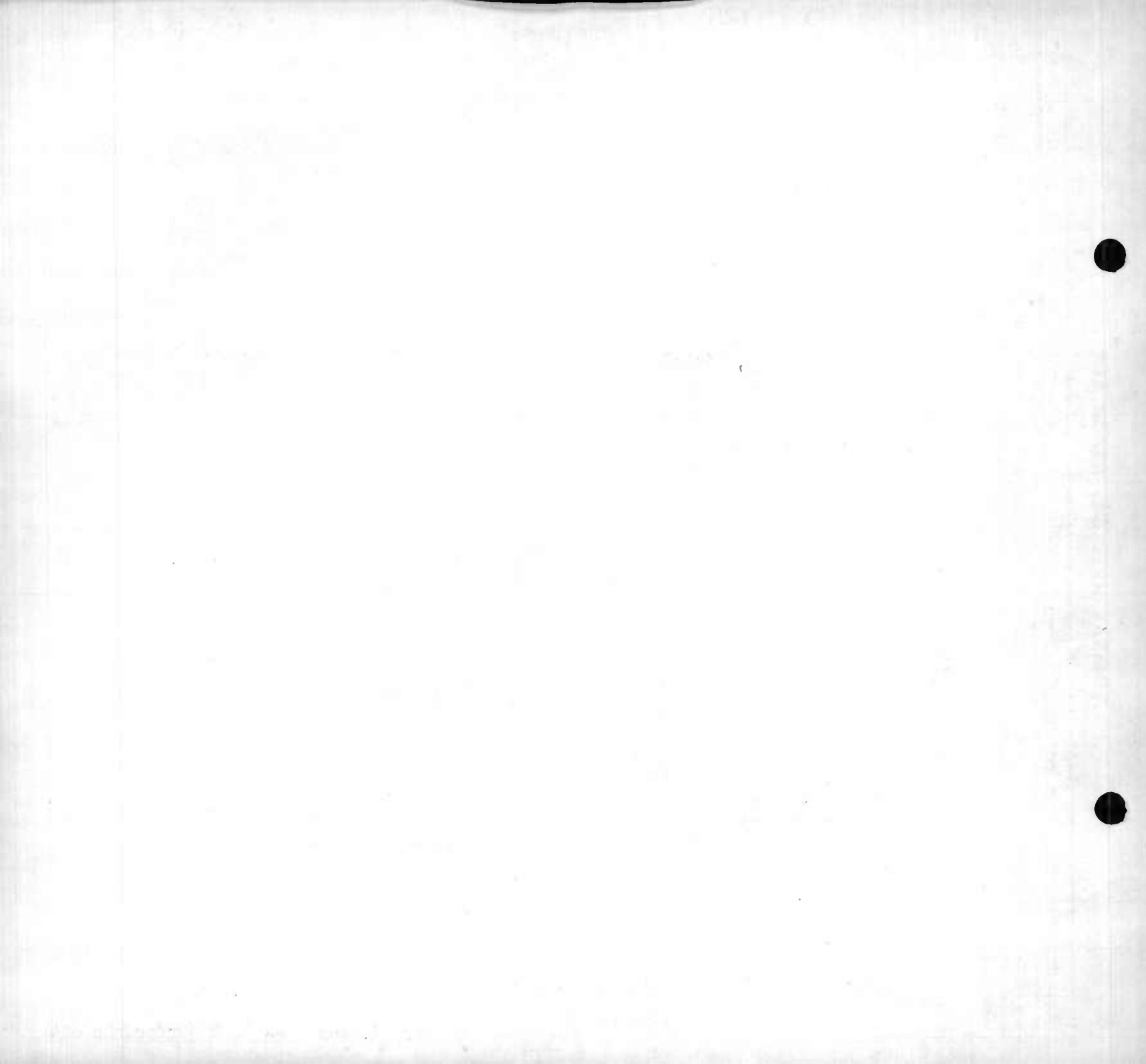
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

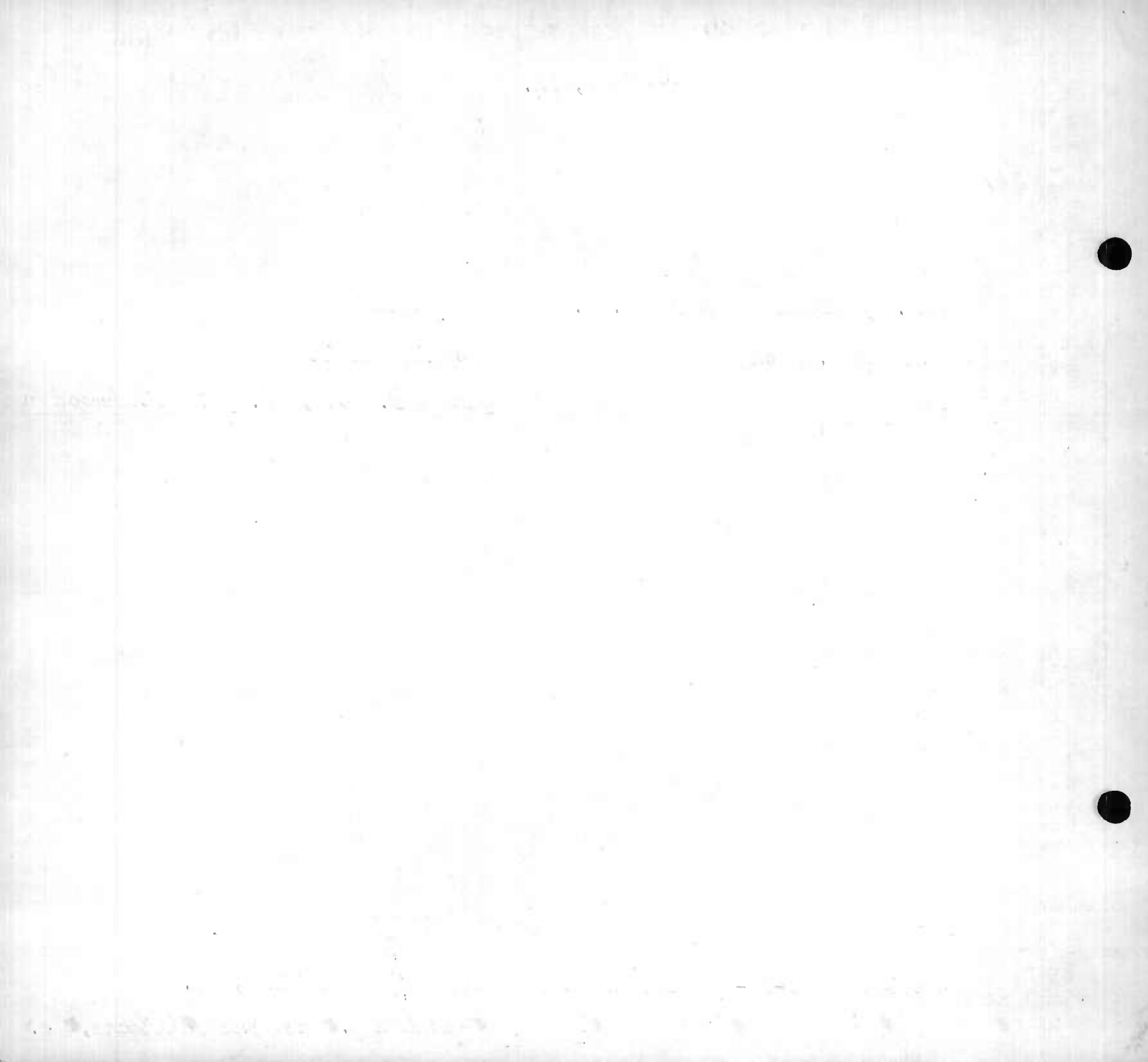
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 8435		CERTIFICATE OF DEATH		Registered No. 65 8435	
1. NAME OF DECEASED (Type or Print) MARY COLSON				2. DATE AND HOUR OF DEATH Aug 15, 1965 1:10 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 5300 D. STREET ADDRESS (If rural, give location) 7829 AIKEN AVE					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 8/4/30	9. AGE (In years lost birthday) 35	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) BALTIMORE, Md		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME VARELLA, Nicholas				14. MOTHER'S MAIDEN NAME WARRIANT Angelina La Viola					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS WM COLSON			
18. 572.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) RESPIRATORY ARREST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. MULTIPLE FECAL FISTULA; ABSCESS ULCERATIVE COLITIS; ABSCESS				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION JUNE 21, 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ULCERATIVE COLITIS		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from June 6, 1965 to Aug 15, 1965 , that (I) (we) last saw the deceased alive on Aug 15, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.									
23A. SIGNATURE Allan Land				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Aug 15, 1965			
23C. PHYSICIAN'S NAME (Type) ALLAN LAND		M.D.		23D. ADDRESS SINAI HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/18/65		24C. NAME OF CEMETERY or CREMATORY Lakeview Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		25B. NAME OF REGISTRAR Robert E. Fairley		25C. FUNERAL DIRECTOR Leonard J. Buck Inc		ADDRESS 5305 Harford Road 14			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8436		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8436	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) George Franklin Cook, Sr.		2. DATE AND HOUR OF DEATH August 13, 1965 3 30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN* (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gould Convalesorium 6116 Beair Rd		D. STREET ADDRESS (If rural, give location) 1257 Battery Ave			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH July 9, 1889	9. AGE (In years lost birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Employee		10B. KIND OF BUSINESS OR INDUSTRY B & O R. R.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Thomas J. Cook		14. MOTHER'S MAIDEN NAME Sophie Schmidt	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 705033730		17. INFORMANT George F. Cook, Jr. 5610 Birchwood Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 420.1 I Arteriosclerotic Cardio Vascular Disease - Myocardial Infarction		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 8 1965 to Aug 13 1965, that (I) (we) last saw the deceased alive on Aug 13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L. G. Tilley		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 13 Aug 65	
23C. PHYSICIAN'S NAME (Type) L. G. Tilley		23D. ADDRESS M.D. 1713 Taylor Ave, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 8-16-65		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965			
25B. NAME OF REGISTRAR Robert E. Feltman		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8437	
BIRTH NO. 65 8437		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) JOHN JOSEPH LAGMA		AUGUST 13, 1965 3 55 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL		A. STATE MARYLAND B. COUNTY BALTIMORE	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21220	
		D. STREET ADDRESS (If rural, give location) 221 BOWLEYS QUARTERS ROAD	
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 11-12-17
		9. AGE (In years lost birthday) 47	10. CITIZEN OF WHAT COUNTRY? UNITED STATES
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTOMOBILE SALESMAN		11. BIRTHPLACE (State or foreign country) MARYLAND	
10B. KIND OF BUSINESS OR INDUSTRY AUTOMOBILES		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME ANTHONY LAGMA		14. MOTHER'S MAIDEN NAME MARY MONROE Menandri	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217146102	
		17. INFORMANT Mrs Rose Mary Martin	
		ADDRESS 1431 Cedarcroft Road	
18. 540.01 x 002.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Upper gastro intestinal hemorrhage from Acute multiple gastric ulcers		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO (B) DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Old Thorax + Tbc (30 years)			
19A. DATE OF OPERATION JULY 30, 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RIGHT PNEUMONECTOMY FOR PREVIOUS OLD THORAX	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 20, 1965 to August 13, 1965 , that (I) (we) last saw the deceased alive on August 13, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Nelson J. Realo, M.D.		23B. DATE SIGNED AUG. 13, 1965	
23C. PHYSICIAN'S NAME (Type) NELSON J. REALO, M.D.		23D. ADDRESS CHURCH HOME AND HOSPITAL BALTO., MD, 21231	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 8-17-65	
24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc		ADDRESS Baltimore, Md.	

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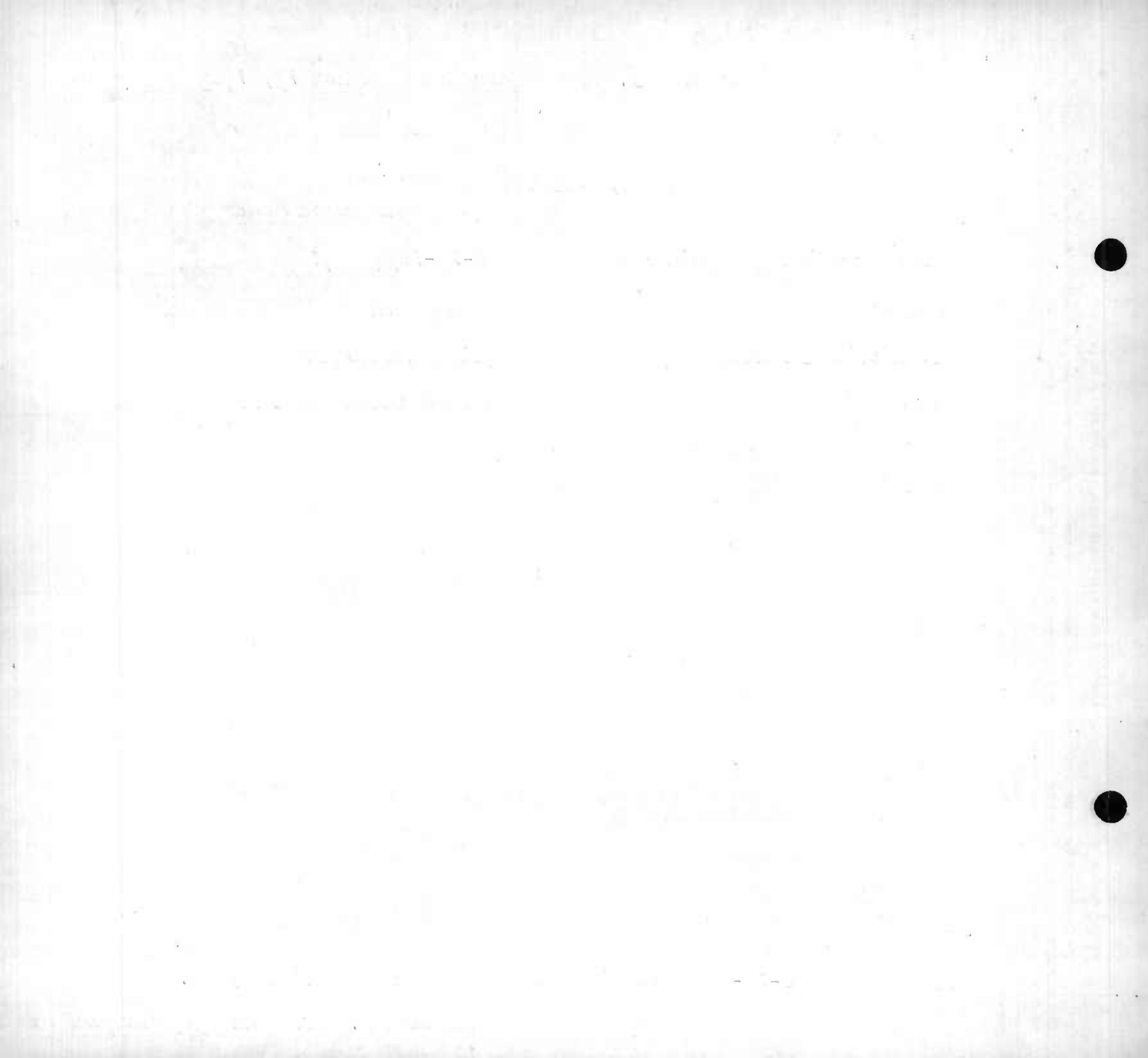
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

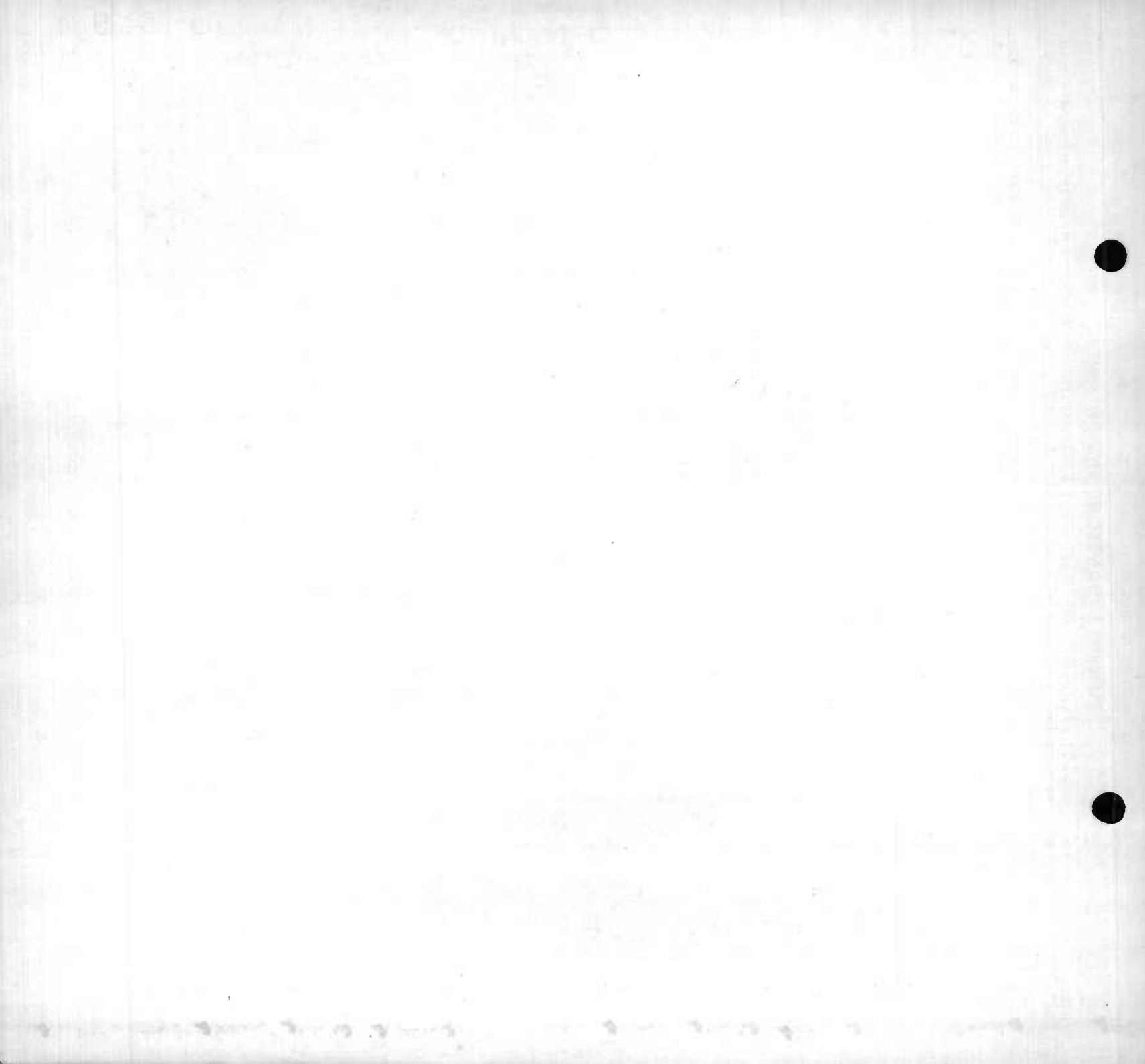
BIRTH NO. 65 8438		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8438	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print) Elizabeth F. Jarvis		2. DATE AND HOUR OF DEATH August 13, 1965		12 Noon M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland B. COUNTY Balt	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) House in the Pines, Belaire		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		53-00	
D. STREET ADDRESS (If rural, give location) 7604 Knollwood Road		5. SEX female		6. RACE white	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed		8. DATE OF BIRTH 8-13-1874		9. AGE (In years lost birthday) 91	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frederick Feldner		14. MOTHER'S MAIDEN NAME Elizabeth Hoehne		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Dorothea Seabold		ADDRESS same	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Coronary Thrombosis (B) DUE TO Anterior Sclerosis (C) Cardio-Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II Semblity			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? III in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 30 th 1965 to Aug 13 th 1965, that (I) (we) last saw the deceased alive on Aug 13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Paul / 13 yr / 4		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/13/65	
23C. PHYSICIAN'S NAME (Type) M Paul / 13 yr / 4		23D. ADDRESS 5820 York Rd Balt 12 Md			
24A. BURIAL CREMATION, REMOVAL (Specify) entombment		24B. DATE 8-16-65		24C. NAME of CEMETERY or CREMATORY Lorraine Park Mausoleum	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc		25D. ADDRESS 5305 Harford Road			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8439				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8439	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Wilma J. Novak				2. DATE AND HOUR OF DEATH 8/15/65 1 45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hosp Balto Md.				A. STATE MD B. COUNTY 8-01			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto				D. STREET ADDRESS (If rural, give location) 3135 Elmora Ave			
5. SEX F	6. RACE CAU	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 12/31/06	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph Janco				14. MOTHER'S MAIDEN NAME Veronica			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Chant	
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Congestive Heart Failure DUE TO (B) Arteriosclerotic Heart Disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3-4 wks	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 8/5 19 65 to 8/15 19 65 , that (H) (we) last saw the deceased alive on 8/14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did-not) view the body after death.							
23A. SIGNATURE Donald T. Lewers MD				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/15/65	
23C. PHYSICIAN'S NAME (Type) Donald T. LEWERS				23D. ADDRESS MD General Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/18/65		24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR Leonard J. Fulk Inc 5305 Harford Road			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 8440

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Thomas (Marshall David) HOLT

2. DATE AND HOUR PRONOUNCED DEAD

8/14/65

1:08 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3811 Reisterstown Road

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

10-5-1941

9. AGE (In years
last birthday)

23

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Caddie

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Marshall Atkinson

14. MOTHER'S MAIDEN NAME

Virginia Staples

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL
SECURITY NO.

17. INFORMANT

Virginia Holt

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Stabwound of heart

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATHII
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

yard

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

3833 Reisterstown Rd.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

8

13

65

11p

m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

stabbed in chest

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S Rudiger Breitenecker
NAME (Type)CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/14/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Aug 18/65

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cemetery

23D. LOCATION

(City, town, or county)

Westport Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

AUG 16 1965

24B. NAME OF REGISTRAR

Robert E. Fagundes

24C. FUNERAL DIRECTOR

Joseph T. Elickson 1129 N. Charles

ADDRESS

65 8441

BALTIMORE CITY HEALTH DEPARTMENT

65 8441

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Raymond R. ALLEN

2. DATE AND HOUR PRONOUNCED DEAD

8/15/65

1.32 aa.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Joseph, s Hosp. DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5. SEX

Male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Sept. 1940 24

9. AGE (In years
last birthday)

24

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Farmville Va

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Robert Allen

14. MOTHER'S MAIDEN NAME

Diane Hertz

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

228-48-4950

17. INFORMANT

Stella Allen 1827 N. Dallas St

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Gunshot wound of head

(A) _____
DUE TO(B) _____
DUE TO

(C) _____

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, street, office bldg.,
etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Preston and Holbrook str.

21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

8

15

65

1

am

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

shot during argument

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

R. Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/15/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

August 19/65

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) & (State)

Farmville Virginia

24A. DATE REC'D BY HEALTH DEPT

AUG 16 1965

24B. NAME OF REGISTRAR

Robert E. Fagundes

24C. FUNERAL DIRECTOR

Frank T. Elickson 1129 N. Calhoun St

ADDRESS

VALLEY FORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

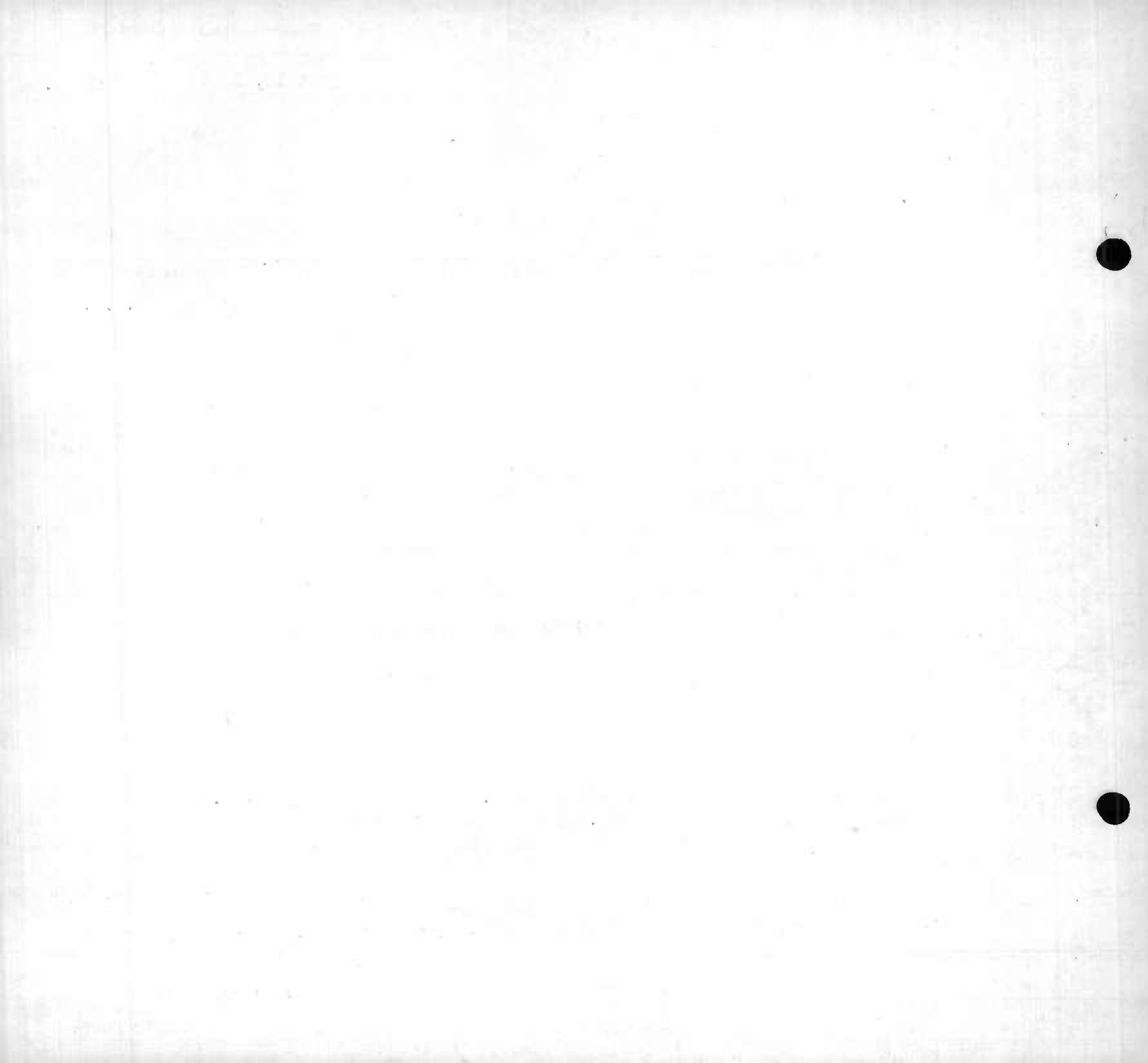
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		65 8442		65 8442	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		Wm. STARKEY		2. DATE AND HOUR OF DEATH 8-13-65 1 6 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland 11-02	
FULL NAME OF DECEASED (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital		9/3/65		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
				D. STREET ADDRESS (If rural, give location) 808 St. Paul Street	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 7-22-96/98	9. AGE (In years last birthday) 69 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Huckster		10B. KIND OF BUSINESS OR INDUSTRY Produce		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Starkey		14. MOTHER'S MAIDEN NAME Emma E. Smart	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Leroy Starkey 1004 Dunblane Road.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) APNEA - UNKNOWN CAUSE DUE TO (B) CHRONIC LUNG DIS. DUE TO BRONCHITIS, EMPHYSEMA (C) ? TUBERCULOSIS		INTERVAL BETWEEN ONSET AND DEATH 15 MIN. 2 YRS.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-11-1965 to 8-13-1965, that (I) (we) last saw the deceased alive on 8-13-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ashley T. Haase		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-13-65	
23C. PHYSICIAN'S NAME (Type) ASHLEY T. HAASE		23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/65		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park	
24D. LOCATION Parkville, Md.		24E. DATE REC'D BY HEALTH DEPT. AUG 16 1965		24F. NAME OF REGISTRAR Robert E. Taylor	
24G. FUNERAL DIRECTOR Ullrich Funeral Home, 4210 Belair Road.		24H. ADDRESS			

vs 153

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8443	
BIRTH NO. 65 8443		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ROTH, JOHN			2. DATE AND HOUR OF DEATH August 13, 1965 2:15 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 26-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 6 D. STREET ADDRESS (If rural, give location) 5101 Conantway		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 4/27/86	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist			11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Henry Roth			14. MOTHER'S MAIDEN NAME Hilda Hoffman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS John N. Roth, 5101 Conant Way		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 177X I Carcinoma of prostate; extensive bony metastases			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Calcific stenosis of aortic valve		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Aug. 12 19 65 to Aug. 13 19 65 , that (I) (we) last saw the deceased alive on Aug. 13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Govinda Rao</i>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 13, 1965
23C. PHYSICIAN'S NAME (Type) Govinda Rao			23D. ADDRESS M.D. 1400 N. Caroline St., Baltimore, Maryland		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/16/65	24C. NAME of CEMETERY or CREMATORY St. John's Cemetery	24D. LOCATION (City, town, or county) (State) Glendale, L.I., N.Y.		
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		25B. NAME OF REGISTRAR <i>Robert E. Fagan</i>	25C. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home 4210 Belair Road.		



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MAY

MENTZLE

2. DATE AND HOUR PRONOUNCED DEAD

August 12, 1965

7:00 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Lutheran Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3306 Elgin Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Jan, 29, 1888

9. AGE (In years
last birthday)

77

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Lawrence Mentzel

14. MOTHER'S MAIDEN NAME

Mary Borgealt

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL
SECURITY NO.

No

17. INFORMANT

ADDRESS

Miss Margaret Mentzel same as # 4

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
8/13/6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/16/65

23C. NAME of CEMETERY or CREMATORY

Western

23D. LOCATION

(City, town, or county)

Baltimore,

Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 16 1965

24B. NAME OF REGISTRAR

Robert E. Finkbeiner, M.D.

24C. FUNERAL DIRECTOR

John T. Stanbury

ADDRESS

6411 Windsor
Mill Rd.

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D. C. 20535

MEMORANDUM FOR THE DIRECTOR

FROM: SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

CLASSIFICATION: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

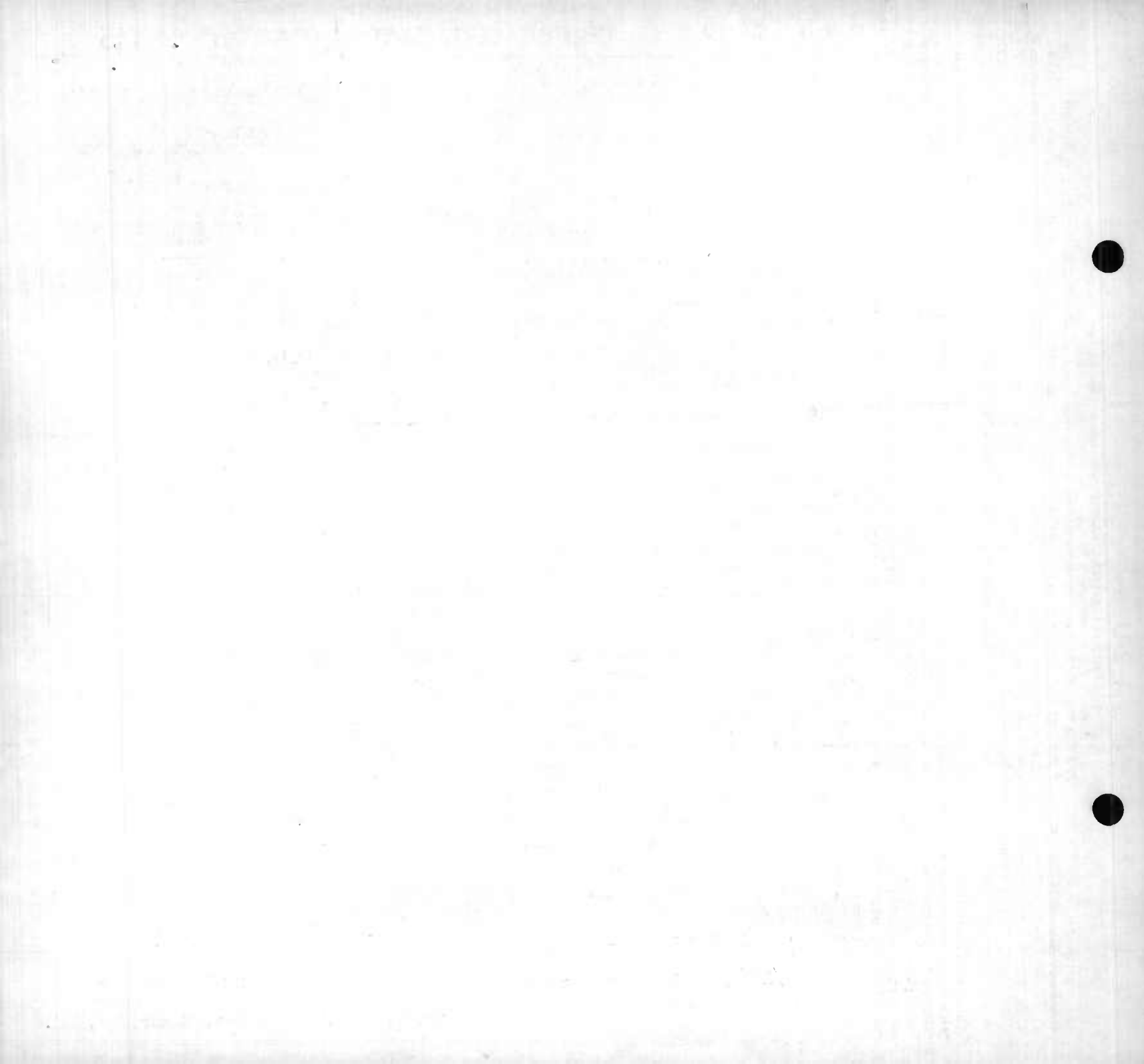
22. [Illegible]

23. [Illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65-8445</u>	
BIRTH NO. <u>65 8445</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Short, Patricia Ann</u>		2. DATE AND HOUR OF DEATH <u>13 August 1965</u> <u>8:05</u> <u>Am</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>		A. STATE <u>Md.</u> B. COUNTY <u>Dorchester</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Cambridge</u>			
		D. STREET ADDRESS (If rural, give location) <u>614 Goldsborough</u>			
5. SEX <u>Female</u>	6. RACE <u>Cauc.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never Married</u>	8. DATE OF BIRTH <u>7-15-59</u>	9. AGE (In years last birthday) <u>6</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Louis Short</u>			14. MOTHER'S MAIDEN NAME <u>Mildred English</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Chart - Father</u>		
18. <u>204.01</u>		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH <u>17 mo.</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <u>Lymphocytic Leukemia</u>			
ANTECEDENT CAUSES		(B) <u>—</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>—</u>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (this hospital) attended the deceased from <u>4 August 1965</u> to <u>13 August 1965</u> , that (we) last saw the deceased alive on <u>13 August 1965</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.					
23A. SIGNATURE <u>D. Gary Benfield</u> M.D.				23B. DATE SIGNED <u>13 August 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>D. Gary Benfield</u> M.D.				23D. ADDRESS <u>University Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/15/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>East New Market Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>East New Market, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 16 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Finkbeiner</u>		25C. FUNERAL DIRECTOR ADDRESS <u>LeCompte Funeral Service, Cambridge, Md.</u>	



1
L-512

65 8446

BALTIMORE CITY HEALTH DEPARTMENT

65 8446

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CARRIE V. ~~LEMBACK~~ LEMBACH

2. DATE AND HOUR PRONOUNCED DEAD

8/14/65 1:56 p.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

925 W. Lombard St.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

4/5/1889

9. AGE (In years last birthday)

76

If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Ind.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

P. Peacock

14. MOTHER'S MAIDEN NAME

Amanda Gerhardt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Charles Lombach - 925 W. Lombard St.

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive heart failure
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic cardiovascular disease
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/14/65

23A. BURIAL CREMATION, REMOVAL (Specify)

burial

23B. DATE

8/17/65

23C. NAME OF CEMETERY or CREMATORY

Linden Park

23D. LOCATION

(City, town, or county)

(State)

Balto. Ind.

24A. DATE REC'D BY HEALTH DEPT.

AUG 18 1965

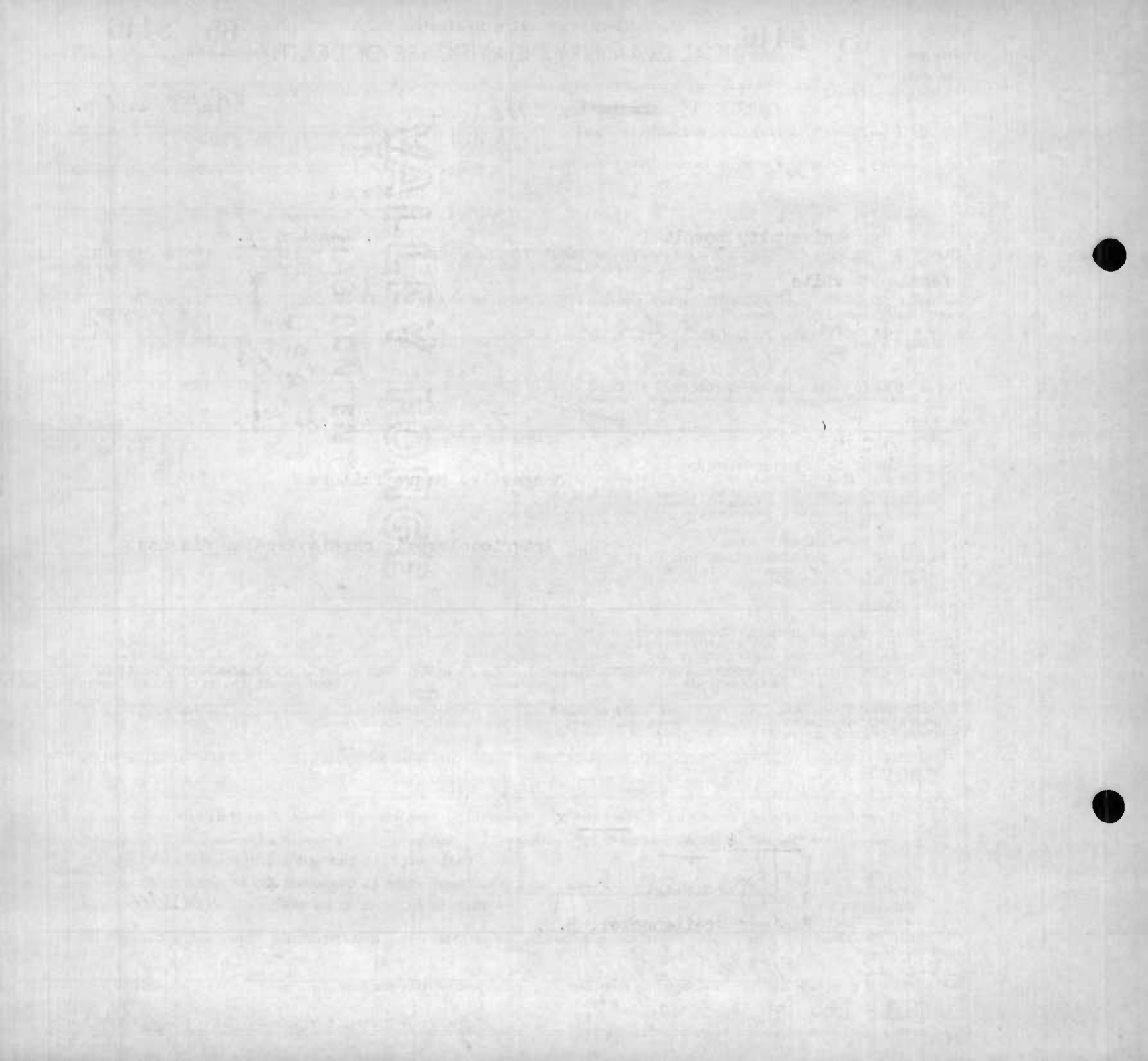
24B. NAME OF REGISTRAR

Robert E. Finken

24C. FUNERAL DIRECTOR

John J. Conner, Inc., Inc. 901 Halling St

ADDRESS



1
E-430

65 8447

BALTIMORE CITY HEALTH DEPARTMENT

65 8447

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HELENE D. ELLIOTT

2. DATE AND HOUR PRONOUNCED DEAD

August 12, 1965 9:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Towson

D. STREET ADDRESS (If rural, give location)

1806 Berrywood Rd

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

June 23, 1938

9. AGE (In years
last birthday)

27

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own home

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Julius J. Kulnar

14. MOTHER'S MAIDEN NAME

Dorothy Mae Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

none

16. SOCIAL
SECURITY NO.

234 213-34-6635

17. INFORMANT

Family records

ADDRESS

18.

164X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Malignant Lymphoma of Mediastinum.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/13/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/16/65

23C. NAME of CEMETERY or CREMATORY

Moreland Memorial Park

23D. LOCATION

(City, town, or county)

(State)

Parkville, Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 16 1965

24B. NAME OF REGISTRAR

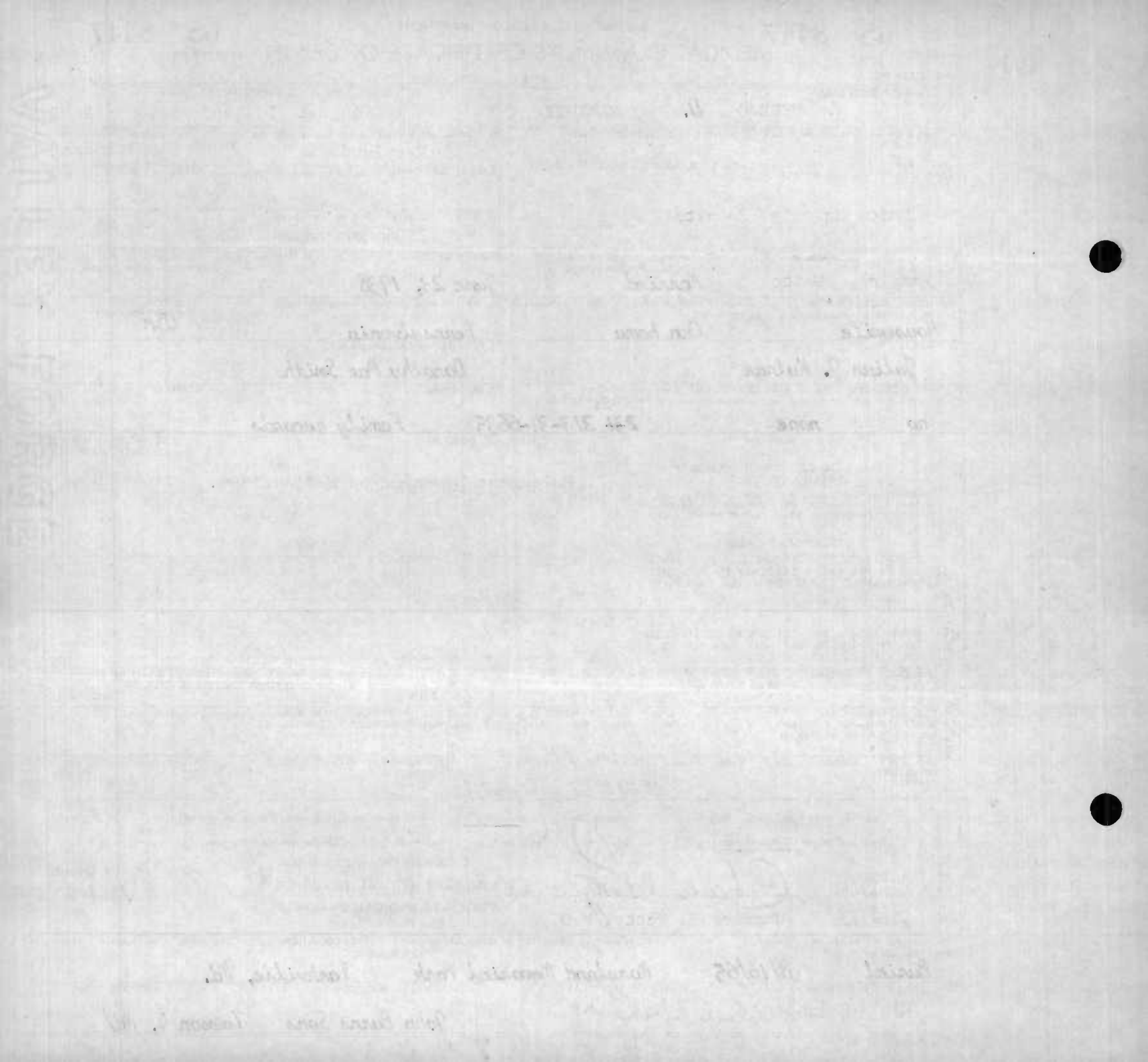
Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

John Burns Sons

Towson 4, Md.

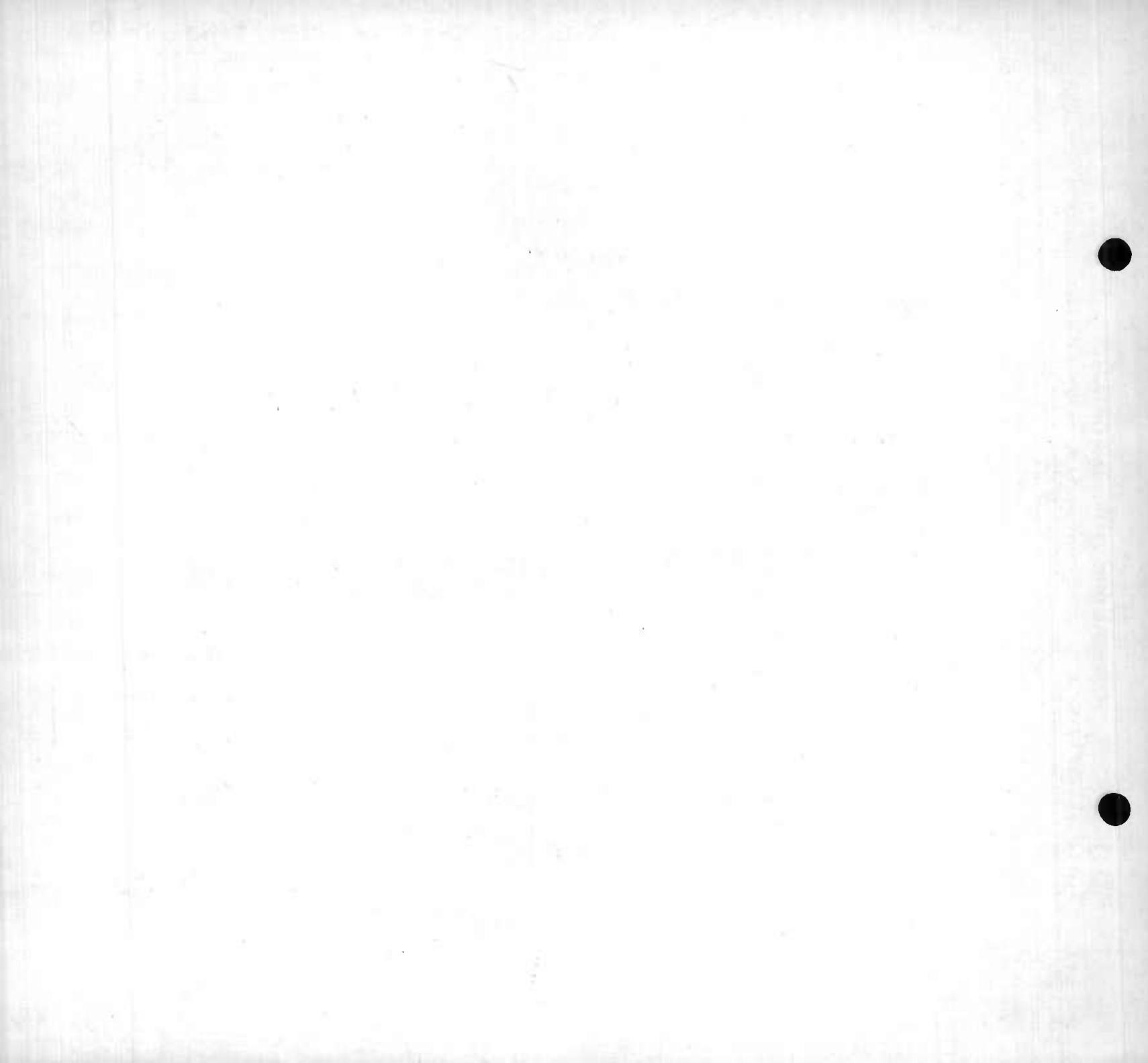
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

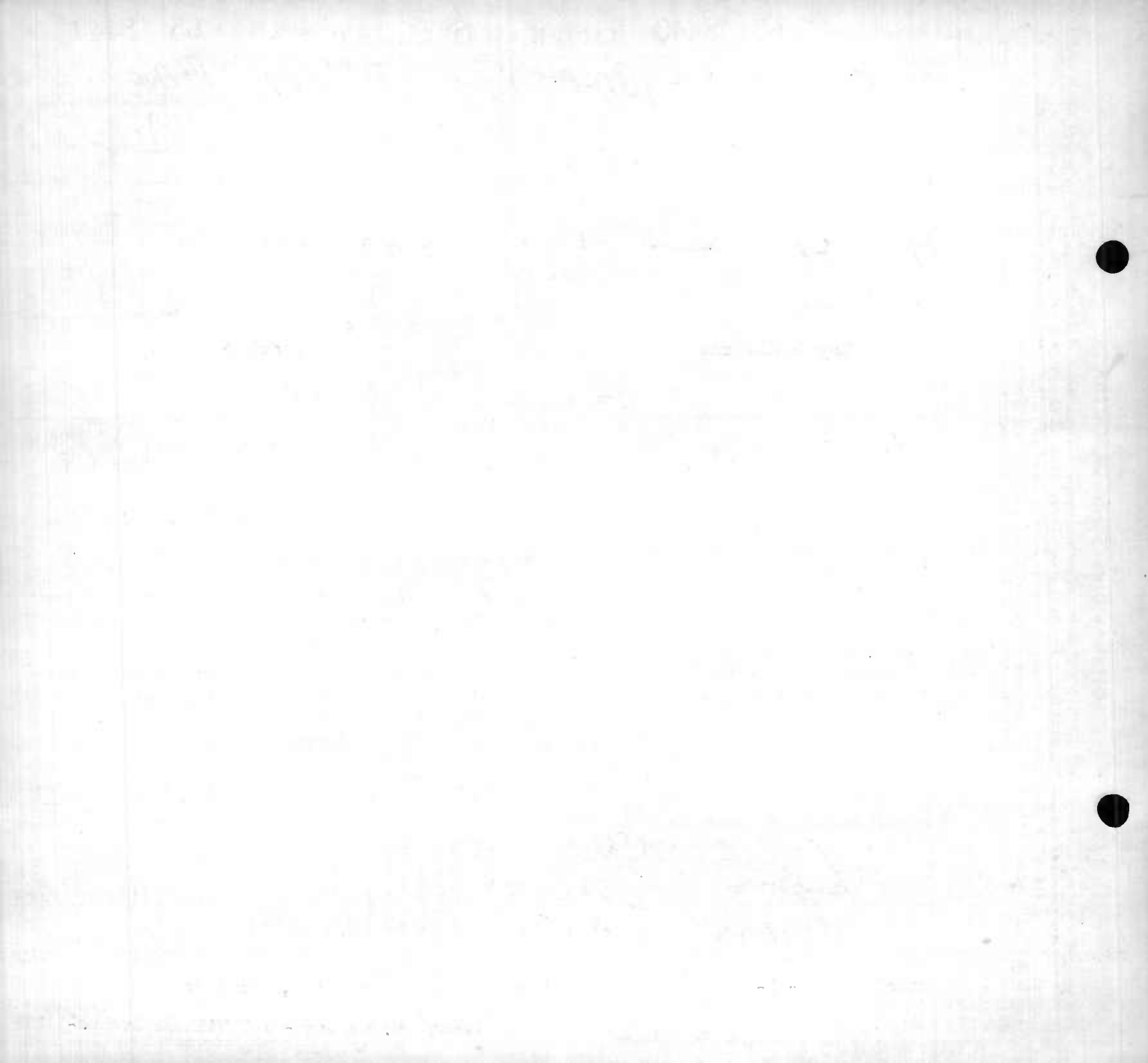
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 8448		CERTIFICATE OF DEATH		65 8448	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		Taylor Marie T.		8/14/65 1 6 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
36 Franklin Square Hosp.		Md. 1309 Herkimer St. Balt. Md.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		D. STREET ADDRESS (If rural, give location)			
		Baltimore Md.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days
Female	White	Widowed	3/26/1908	57	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Machine operator Paper Box Co.				Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Joseph Hullett		Unknown		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Mrs Virginia Schnick above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) Cardiac Arrest		1 hr	
ANTECEDENT CAUSES		(B) Myocardial Infarction		? one day	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Coronary Artery Disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Aug. 14 1965 to Aug. 14 1965, that (I) (we) last saw the deceased alive on Aug. 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Raymundo S. MAGNO		8/14/65			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Raymundo S. MAGNO		Franklin Square Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8/17/65		London Park Cem.	
25A. DATE REC'D BY HEALTH/DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 16 1965		Robert E. Fagan		John J. Cowan & Son Inc. 291 Gollins St. Balt. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

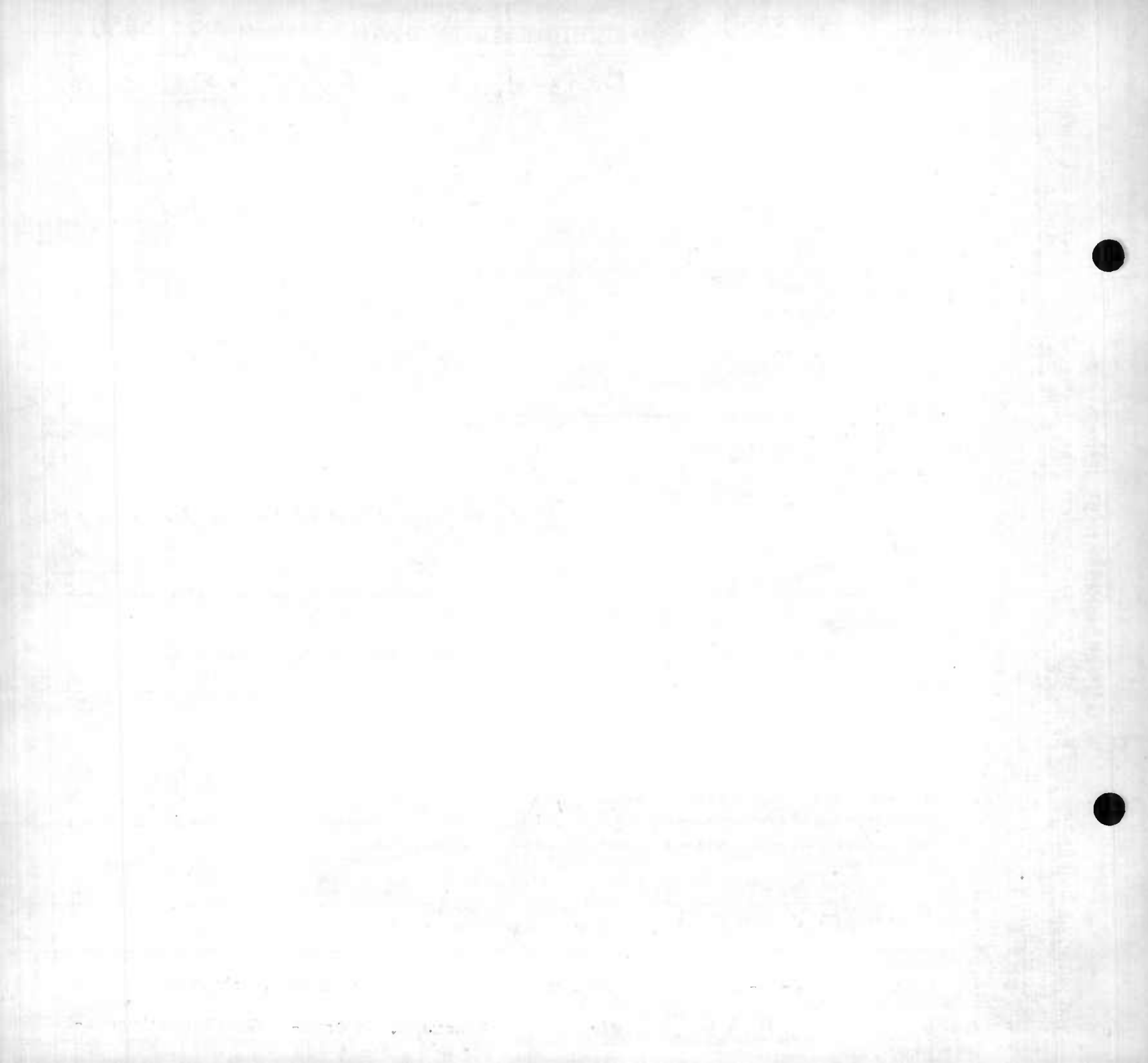
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8449	
BIRTH NO. 65 8449		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 22 AM 14 AUGUST 1965	
1. NAME OF DECEASED (Type or Print) COULBOURNE, RALPH S.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION USPHS HOSPITAL BALTIMORE		A. STATE VA.	
(If not in hospital or institution, give street address or location)		B. COUNTY	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) V-43	
		D. STREET ADDRESS (If rural, give location)	
5. SEX M	6. RACE W	7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED <input type="checkbox"/> WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 11-2-03
		9. AGE (In years lost birthday) 62	11. BIRTHPLACE (State or foreign country) VA.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FISHERMAN		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ray Coulbourne		14. MOTHER'S MAIDEN NAME Pearl Townsend	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 231-05-0103	17. INFORMANT CHART
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) PULMONARY EDEMA DUE TO (B) MYOCARDIAL INFARCTION DUE TO (C) ATHEROSCLEROSIS	
		INTERVAL BETWEEN ONSET AND DEATH HOURS DAYS YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		AORTIC STENOSIS @ INSUFFICIENCY	
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5 AUGUST 19 65 to 14 AUGUST 19 65 , that (I) (we) last saw the deceased alive on 14 AUGUST 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Thomas L. Hall M.D.		23B. DATE SIGNED 14 AUGUST 1965	
23C. PHYSICIAN'S NAME (Type) THOMAS L. HALL M.D.		23D. ADDRESS USPHS HOSPITAL BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-17-65	24C. NAME OF CEMETERY OR CREMATORY Dowings Cemetery	24D. LOCATION (City, town, or county) (State) Oak Hall, Virginia
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965	25B. NAME OF REGISTRAR Robert E. Hubbard	25C. FUNERAL DIRECTOR Howard H. Hubbard ADDRESS 4107 Wilkens Avenue-21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 8450		CERTIFICATE OF DEATH		Registered No. 65 8450	
1. NAME OF DECEASED (Type or Print) <i>Charles Frances Batzer, Sr.</i>				2. DATE AND HOUR OF DEATH <i>8/15/65 3-15 A.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Bon Secout Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>3673 McTavish Ave.</i>					
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>5/27/1909</i>	9. AGE (In years last birthday) <i>56</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Control clerk</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>B.T.C.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>John Batzer</i>			14. MOTHER'S MAIDEN NAME <i>Margaret Krieger</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			
16. SOCIAL SECURITY NO. <i>213-10-3067</i>			17. INFORMANT <i>Mrs. Clare M. Batzer</i>				ADDRESS <i>-3673 McTavish Ave</i>		
18. <i>420.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) <i>Ventricular fibrillation</i> DUE TO (B) <i>Massive myocardial infarction - hours</i> DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>8/15/65</i> 19 to <i>8/15/65</i> 19, that (I) (we) last saw the deceased alive on <i>8/15/65</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Octavio A Ruiz</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>						23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <i>Octavio A Ruiz</i> M.D.						23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-18-65</i>		24C. NAME of CEMETERY or CREMATORY <i>Holy Redeemer</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 16 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <i>Howard H. Hubbard</i>		ADDRESS <i>4107 Wilkens Avenue-21229</i>			



FUNERAL DIRECTOR: IMPORTANT

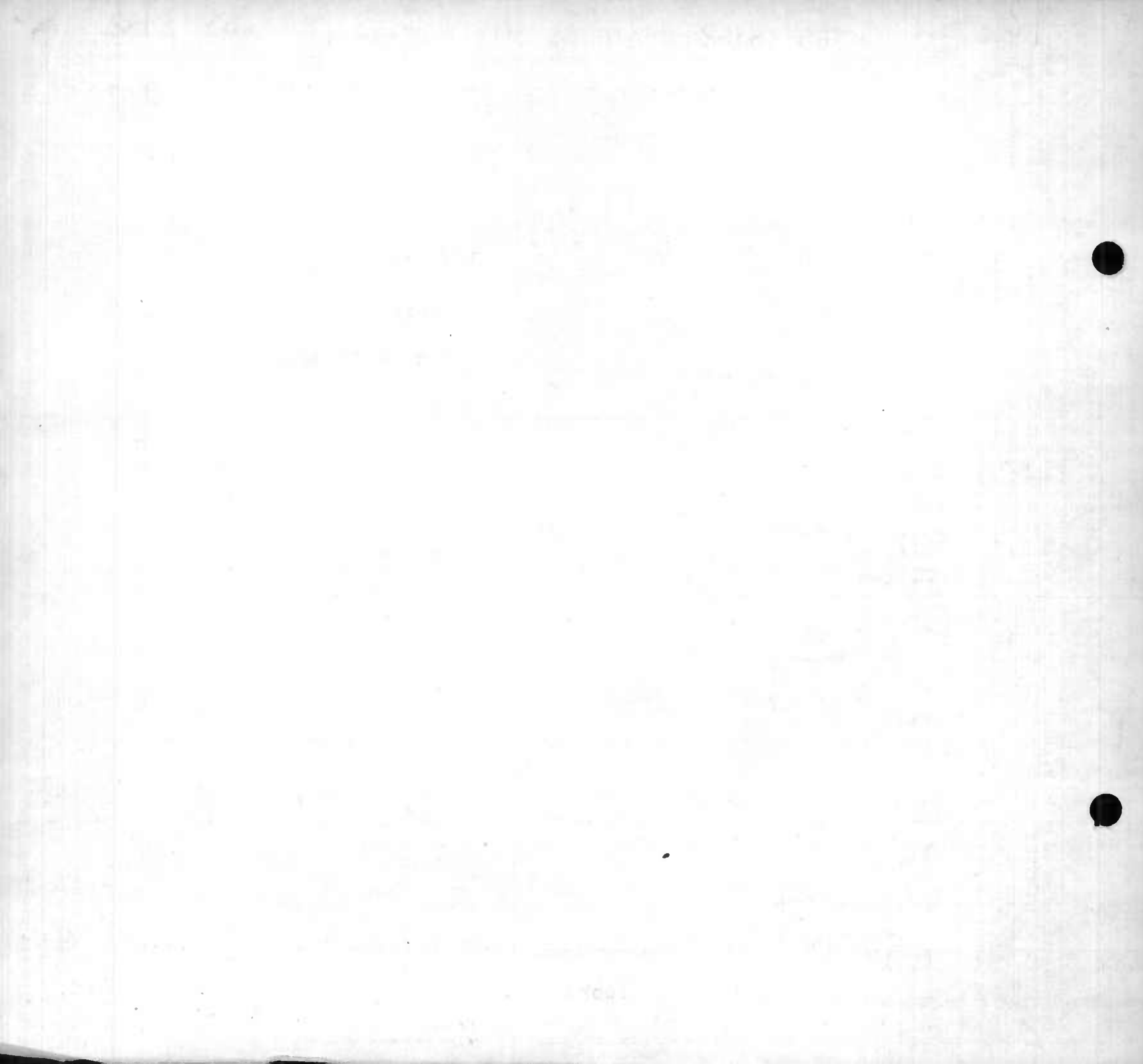
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65 8451					Registered No. 65 8451				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
C. Franklin Grill, Sr.					8-13-65				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
St. Agnes Hospital					Maryland Baltimore				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					Arbutus 6300				
					D. STREET ADDRESS (If rural, give location)				
					5217 Benson Avenue				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
Male	White	Married		1-5-98	67				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Meat Inspector			U.S. Government		Baltimore, Md.				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
William H. Grill					Mimmie Otto				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No			215-12-3726		Mrs. Ora J. Grill-5217 Benson Avenue-21227				
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH				
					(A) M/OCARDIAL INFARCTION SUDDEN				
					(B) HYPERTENSION				
					(C) GENERALIZED ARTERIOSCLEROSIS				
19. 420.1 I DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from MAY 1960 to 2 August 1965, that (I) (we) last saw the deceased alive on 2 August 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
George E. Groleau					14 August 65				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
George E. Groleau					M.D. 5608 Main Street, Elkridge, Md.				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		8-17-65		Loudon Park Cemetery		Baltimore, Maryland.			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS				
AUG 16 1965			Robert E. Fisher		Howard H. Hubbard-4107 Wilkens Avenue-21229				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

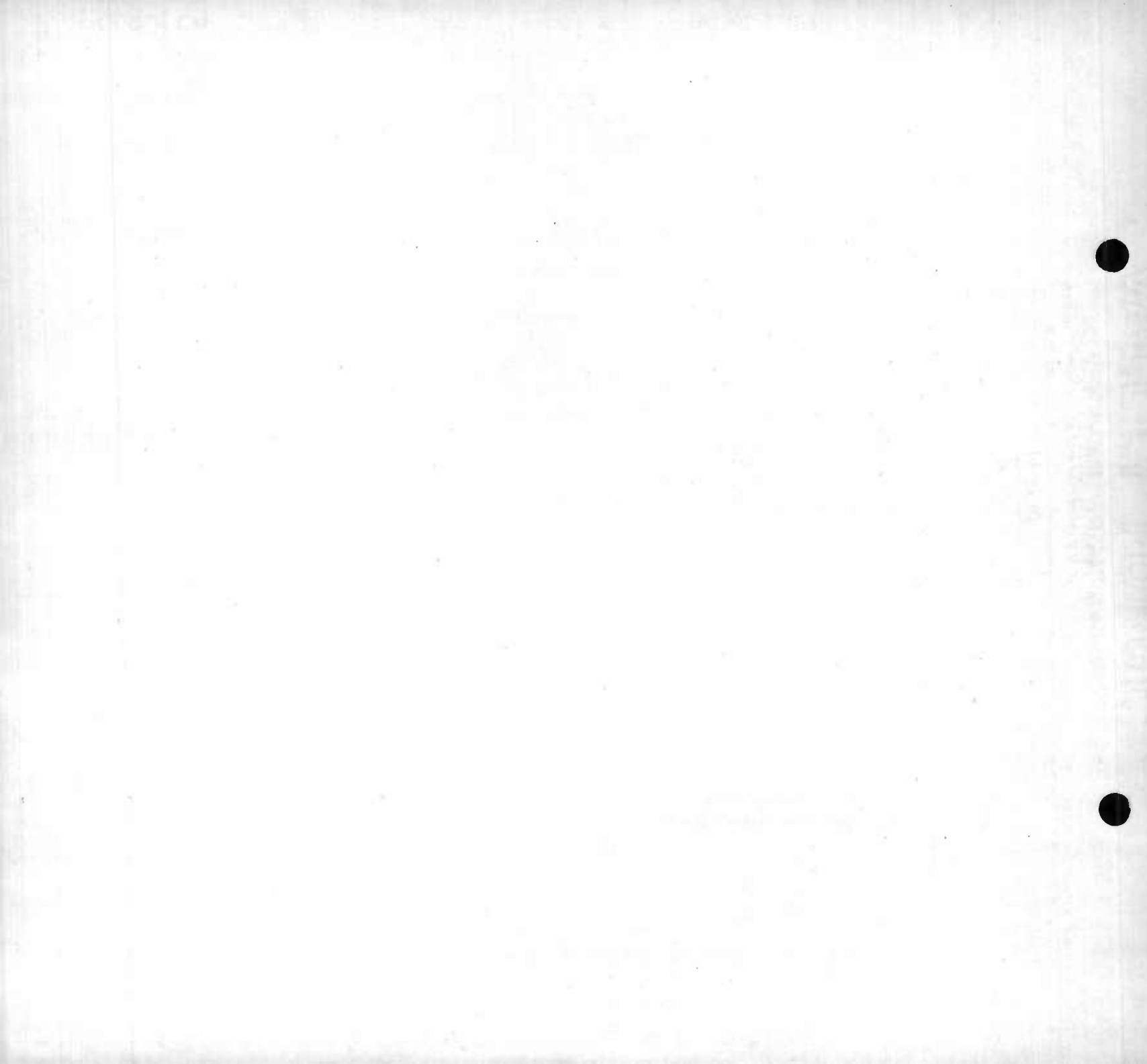
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO.		65 8452		CERTIFICATE OF DEATH			Registered No. 65 8452		
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <u>Eliza Reynolds</u>				2. DATE AND HOUR OF DEATH <u>8-12-65</u> <u>8:45 P. M.</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY			
				<u>Maryland</u>		<u>Calvert</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		<u>Island Creek</u>		<u>54-00</u>	
				D. STREET ADDRESS (If rural, give location)					
<u>Bar-Wil-Ba Convalescent Home</u>									
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.	
<u>F.</u>	<u>Col.</u>	<u>W.</u>		<u>10/18/1882</u>	<u>82</u>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Domestic</u>						<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
<u>Unknown</u>				<u>Jane Hawkins</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
						<u>Patient's admission record</u>			
18. <u>420.0</u>				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) <u>Arteriosclerotic heart disease</u> DUE TO					
ANTECEDENT CAUSES				(B) <u>Generalized arteriosclerosis</u> DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
<u>0</u>				<u>No</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from <u>9-20-</u> <u>1964</u> to <u>8-12-</u> <u>1965</u> , that (I) (we) lost saw the deceased alive on <u>8-12-</u> <u>1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED	
<u>C.R. Campbell</u>								<u>8-12-65</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
<u>C.R. Campbell</u>				<u>M.D. 1618 W. North Ave. Baltimore, Md.</u>					
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
<u>8/15/65</u>		<u>Brooks Cem.</u>		<u>Calvert Co.</u>		<u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
<u>AUG 16 1965</u>		<u>P. E. Seabell</u>		<u>P. E. Seabell</u>		<u>Prince Frederick, Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

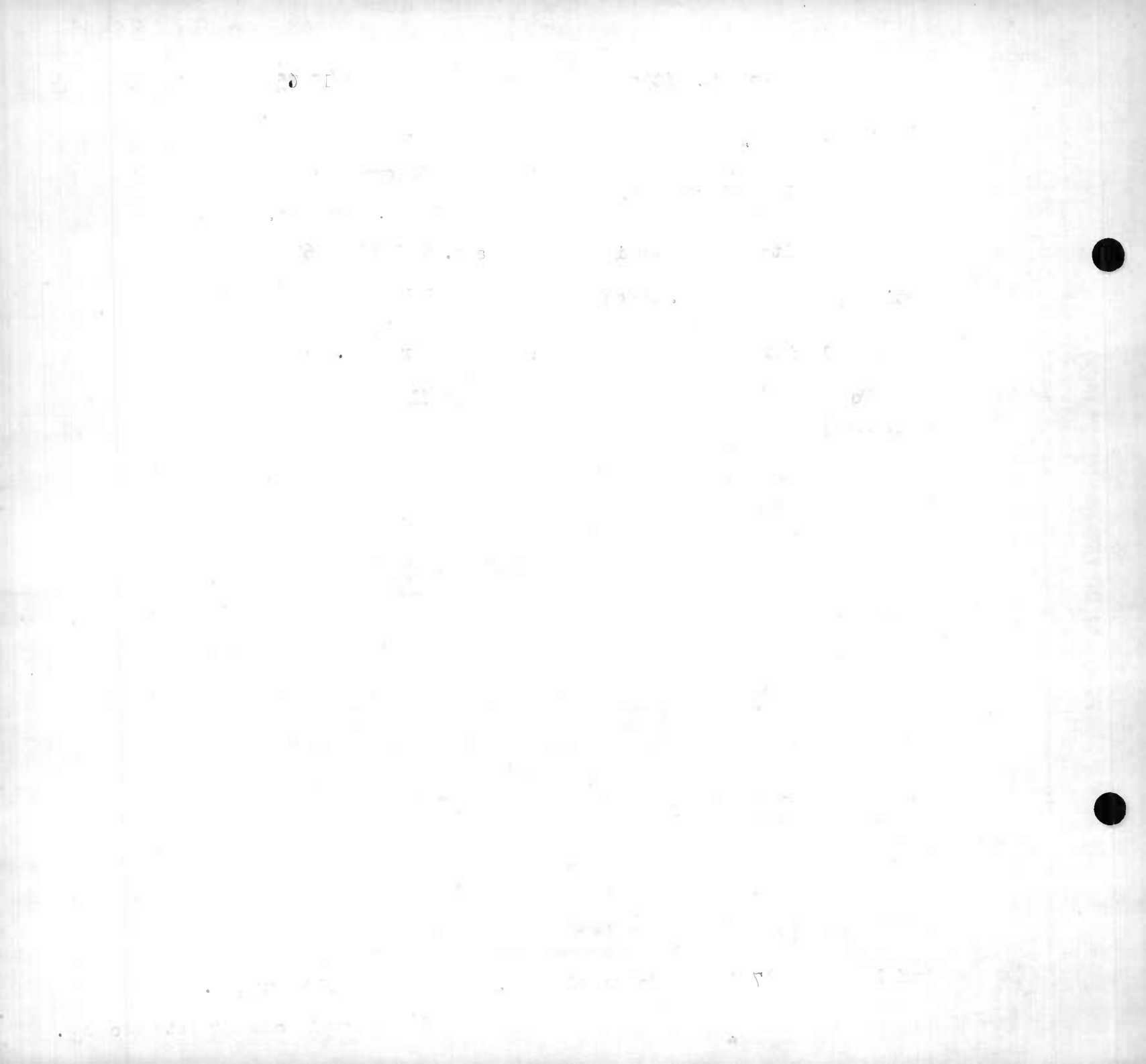
BIRTH NO. 65 8453		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8453	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Charles N. Hughes</i>			2. DATE AND HOUR OF DEATH <i>Aug 12, 1965</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>2415 Arbuton Ave 30</i>			A. STATE <i>Md</i> B. COUNTY <i>25-42</i>		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			D. STREET ADDRESS (If rural, give location) <i>2415 Arbuton Ave.</i>		
5. SEX <i>Male</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Sept 15, 1891</i>	9. AGE (In years last birthday) <i>73</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>B&O</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>William B. Hughes</i>		14. MOTHER'S MAIDEN NAME <i>Bertha Tall</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family</i>	
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>myocardial infarction</i> DUE TO <i>Arteriosclerotic cardiovascular</i> (B) <i>Dissecting</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Emphysema</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLIERING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>January 1964</i> to <i>August 1965</i> , that (I) (we) last saw the deceased alive on <i>Aug 2 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>George Vash</i>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>8/13/65</i>
23C. PHYSICIAN'S NAME (Type) <i>VASH</i>			23D. ADDRESS <i>2061 S. Gilman St, B.2</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/16/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Olivet</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		24E. (State) <i>Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 16 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fadden</i>		25C. FUNERAL DIRECTOR <i>McElroy</i>	
25D. ADDRESS <i>237 Fatapaco Ave 25</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

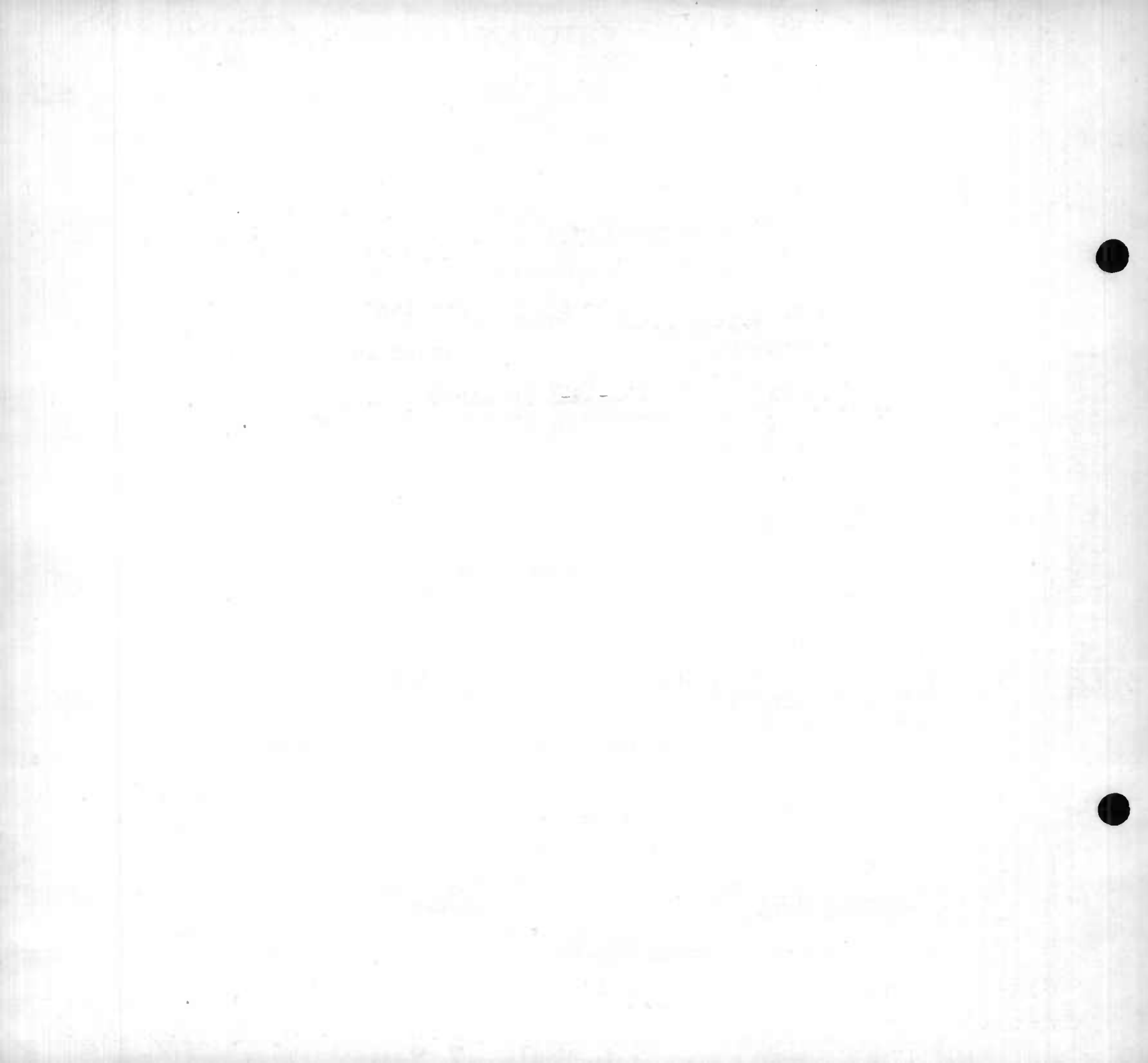
BIRTH NO. 65 8454				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8454	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				John R. Pitts		8/13/65 1:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				Md.		B. COUNTY	
410 Washburn Ave.				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
				D. STREET ADDRESS (If rural, give location)		410 Washburn Ave.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.
M	White	Married	Apr. 22, 1896	69			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Retired			Md. Drydock		7 Alabama		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Vicheal Pitt				Sara E.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No						Family	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
				coronary occlusion			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				coronary artery disease & hypertension w/ dis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 1949 to Aug 13, 1965, that (I) (we) last saw the deceased alive on Aug 12, 65, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Philip W. Keister MD				8/13/65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
P. W. KEISTER				302 Patapsco Ave			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/18/65		Cedar Hill Cem.		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 16 1965		P. W. Keister		McCully Funeral Home		237 Patapsco Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8455		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8455	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Ada Baker Smith		2. DATE AND HOUR OF DEATH 8-12-65 5:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Wicomico		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Salisbury	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIV of MD. Hospital		D. STREET ADDRESS (If rural, give location) 607 Liberty St.		E. AGE (In years lost birthday) 60	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 2-25-05	9. AGE (In years lost birthday) 60	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joshua Baker		14. MOTHER'S MAIDEN NAME Beulah Tull	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) xx		16. SOCIAL SECURITY NO. 221-12-4854		17. INFORMANT Harold Smith 607 Liberty St	
18. 754.71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerosis, Congestive Cardiac		CAUSE OF DEATH Salisbury, Md.		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) DUE TO		(B) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION 1-89-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Arteriosclerosis		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-6-65 19 to 8-12-65 19, that (I) (we) lost saw the deceased alive on 8-12-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-12-65	
23C. PHYSICIAN'S NAME (Type) [Signature]		23D. ADDRESS [Signature]			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/15/65		24C. NAME of CEMETERY or CREMATORY Memorial Park	
24D. LOCATION (City, town, or county) (State) Salisbury, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		25B. NAME OF REGISTRAR Robert E. Fisher, Md.	
25C. FUNERAL DIRECTOR [Signature]		25D. ADDRESS [Signature]			



65 8456		BALTIMORE CITY HEALTH DEPARTMENT		65 8456	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD	
MARY E. LEGGETT				8/10/65 11:25 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland	
				B. COUNTY Baltimore	
2607 Bruce Terrace				13-03	
5. SEX female		6. RACE colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow	
8. DATE OF BIRTH July 25, 1898		9. AGE (In years last birthday) 67		10. UNDER 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11. BIRTHPLACE (State or foreign country) Maryland	
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME U nknown				14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Benjamin Fleet	
				ADDRESS 2804 Woodbrook Ave.	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO					
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 8-12-65		23C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem	
24A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		24B. NAME OF REGISTRAR Robert E. Fink		24C. FUNERAL DIRECTOR Mrs. Frances A. Hensley	
				ADDRESS 70 W. Biddle St.	

VALLEY POLICE

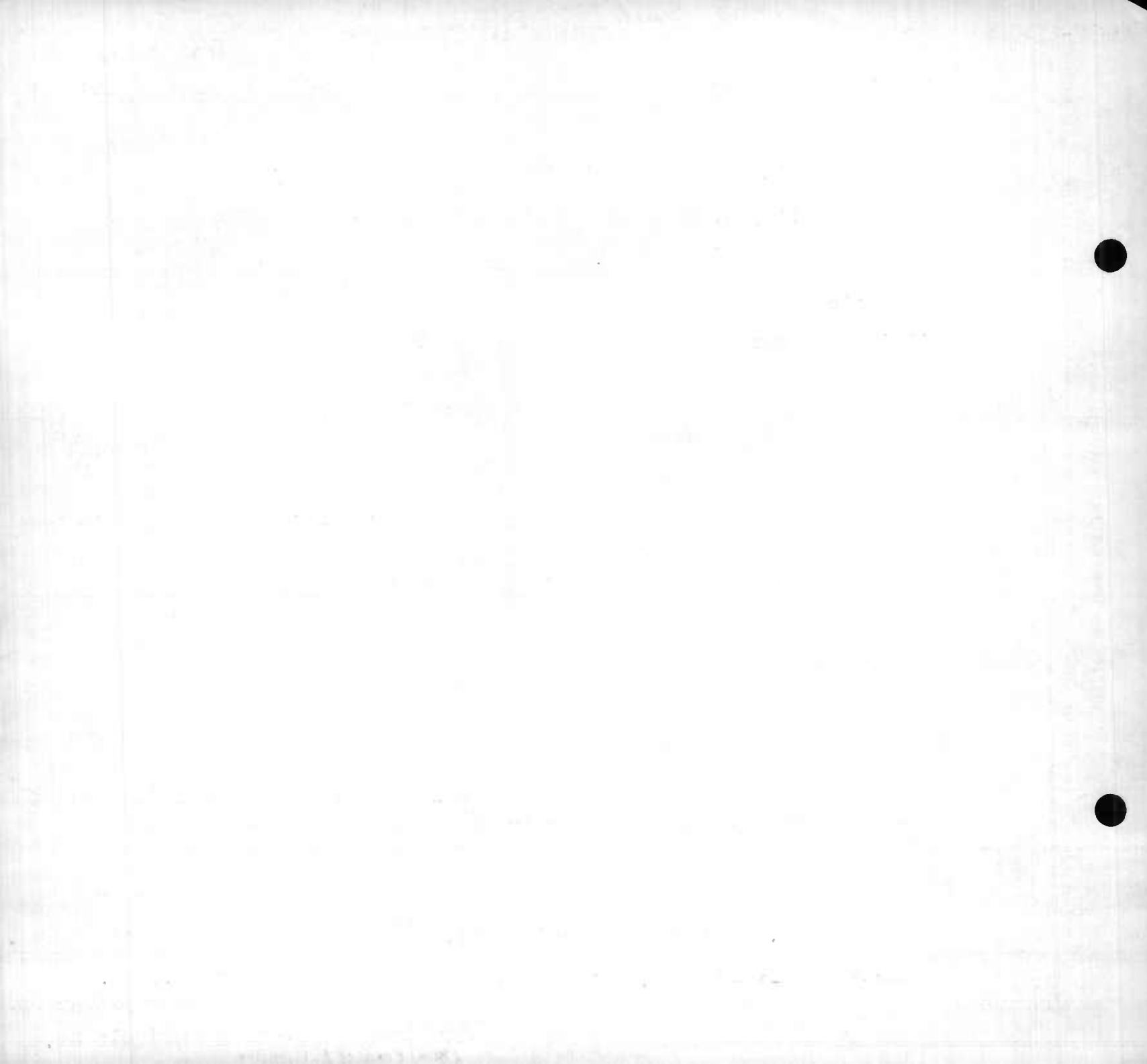
CHIEF OF POLICE

MEMORANDUM FOR THE CHIEF OF POLICE
SUBJECT: [Illegible]
DATE: [Illegible]
TO: [Illegible]
FROM: [Illegible]
[The following text is illegible due to extreme fading and bleed-through from the reverse side of the page.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. C-516 65 8457				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8457	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Lillie Camphor				2. DATE AND HOUR OF DEATH 8-11-65 5:30 AM.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE Maryland B. COUNTY 15-01			
5. SEX Female				6. RACE Negro		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	
8. DATE OF BIRTH Unknown				9. AGE (In years last birthday) 85		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Camphor				12. CITIZEN OF WHAT COUNTRY? USA			
14. MOTHER'S MAIDEN NAME ?				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT BCH:RECORDS:4940 Eastern Avenue 21224			
18. 260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac arrhythmia Arteriosclerotic heart disease				INTERVAL BETWEEN ONSET AND DEATH Moment of death			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Diabetes mellitus-Mild Undetermined			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8-6-19 65 to 8-11-19 65 , that (I) (we) last saw the deceased alive on 8-11-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. Leonard Quadracci M.D.				23B. DATE SIGNED 8-11-65		23C. PHYSICIAN'S NAME (Type) Dr. Leonard Quadracci	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 8-14-65		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem	
24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Md.				25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		25B. NAME OF REGISTRAR Robert E. Farber	
25C. FUNERAL DIRECTOR (Mrs) Frances A. Hemeler				25D. ADDRESS Biddle St.		25E. ADDRESS 578 W	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8458		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8458	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) Rhoda Englar		
2. DATE AND HOUR OF DEATH 8/10/65 12:29 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-09 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Maryland D. STREET ADDRESS (If rural, give location) 1521 Northwick Rd		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 8/21/77	9. AGE (In years lost birthday) 87	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Waynesboro, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME DANIEL B. MENTZER			14. MOTHER'S MAIDEN NAME ELIZABETH GOOD		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT MRS JOHN B BLAKENEY ADDRESS S/A		
18. 332X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO Soner arteriosclerosis and embolism of the cerebral arteries. (B) DUE TO especially R. middle cerebral. (C)		INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 8/6/65 19 65 to 8/10 19 65 , that the (we) last saw the deceased alive on 8/10 19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did not) view the body after death.					
23A. SIGNATURE Robert N Whitlock				23B. DATE SIGNED 8/10/65	
23C. PHYSICIAN'S NAME (Type) ROBERT N. WHITLOCK,		23D. ADDRESS M.D. UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 8-11-65		24C. NAME OF CEMETERY or CREMATORY Green Mount	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home	
				ADDRESS 6500 York Rd.	

RECEIVED

John H. White

8/10

8/10/2

8/10

8/10/2

RECEIVED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8459		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 8459	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HUDGINS LUTHER J.		2. DATE AND HOUR OF DEATH 8-13-65 9:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL INC		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO	
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M	
8. DATE OF BIRTH 12-24-07		9. AGE (In years lost birthday) 57		10. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. BIRTHPLACE (State foreign country) N. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME MONROE HUDGINS	
14. MOTHER'S MAIDEN NAME EVANGELINE HUDGINS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-09-3663	
17. INFORMANT Mrs. Hazel I. Hudgins		ADDRESS 1607 Chilton St,		18. 332X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Encephalomalacia Cerebral Thrombosis	
19. DATE OF OPERATION		20. AUTOPSY? (Yes or No) —		21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
22. I certify that (I) (this hospital) attended the deceased from Aug 4 19 65 to Aug 13 19 65 , that (I) (we) lost saw the deceased alive on Aug 13, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Ruperto Manankil M.D.		23B. DATE SIGNED 8/13/65	
23C. PHYSICIAN'S NAME (Type) RUPERTO MANANKIL M.D.		23D. ADDRESS MERCY HOSPITAL INC		24A. BURIAL CREMATION REMOVAL (Specify) Burial	
24B. DATE 8-17-1965		24C. NAME OF CEMETERY or CREMATORY Baltimore		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		25B. NAME OF REGISTRAR Robert E. Jankins		25C. FUNERAL DIRECTOR ADDRESS G. Howard Strong 3207 W. North Ave.,	

2. 2

McKee's Hardware
Security Officer
M. W. M.
1907-08

General Thompson

Rupert's Hardware
Rupert's Hardware
1907-08

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8460	
BIRTH NO. 65 8460		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Julius G. Maurer		2. DATE AND HOUR OF DEATH 8-14-65 7:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GEN. Hospital		A. STATE Maryland B. COUNTY 25-41 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3606 Wilkens Ave 21229			
5. SEX MALE	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3-25-00	9. AGE (in years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10B. KIND OF BUSINESS OR INDUSTRY Law		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Rudolph Maurer		14. MOTHER'S MAIDEN NAME Anna Horn			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-10-8658		17. INFORMANT Patient-Julius G. MAURER	
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Renal failure DUE TO Arteriosclerosis advanced stage (B) Hypertensive Cardio DUE TO Vascular and renovascular disease (C) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 17 1965 to August 14 1965 , that (I) (we) lost saw the deceased alive on August 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. Michael Gould M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 8-14-65	
23C. PHYSICIAN'S NAME (Type) W. Michael Gould M.D.				23D. ADDRESS Linden Ave. & Madison	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug-17-65		24C. NAME OF CEMETERY or CREMATORY Touhon Park Cem. Baltimore - Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		25B. NAME OF REGISTRAR Robert E. Gould		25C. FUNERAL DIRECTOR By R. E. Gould - 2300 E. 17th	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 65 8461					CERTIFICATE OF DEATH					Registered No. 65 8461									
M.E. CASE NO.										1. NAME OF DECEASED (Type or Print) Kelly, George Stanley									
2. DATE AND HOUR OF DEATH Aug. 13, 1965 4:30 A. M.										3. PLACE OF DEATH IN BALTIMORE, MARYLAND									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U.S. Public Health Service Hospital Wyman Park Dr. and 31st. St.										4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Baltimore									
5. SEX M 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Divorced										8. DATE OF BIRTH Aug. 19, 1929 9. AGE (In years last birthday) 35									
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired										10B. KIND OF BUSINESS OR INDUSTRY USN									
11. BIRTHPLACE (State or foreign country) Maryland										12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME George T. Kelly										14. MOTHER'S MAIDEN NAME Edith Zink									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USN - 1951-1953										16. SOCIAL SECURITY NO. 214 24 1453									
17. INFORMANT ADDRESS Records- USPHS Hospital, Baltimore, Md.										18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(A) Subdural and subarachnoid hemorrhage (B) Grand mal epilepsy (C)									
INTERVAL BETWEEN ONSET AND DEATH 5 days 13 yrs.										II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 3 8/9/65										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Subdural hematoma									
20A. AUTOPSY? (Yes or No) yes										20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>										21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home									
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 6015 Sycamore Rd. Balto, Md.										21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 8/8/65									
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>										21F. HOW DID INJURY OCCUR? Patient fell									
22. I certify that (X) (this hospital) attended the deceased from Aug. 8 19 65 to Aug. 13 19 65, that (X) (we) last saw the deceased alive on Aug. 13 19 65 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (XXXX) view the body after death.										23A. SIGNATURE Thomas J. Lai, Surgeon (R)									
23B. DATE SIGNED Aug. 13, 1965										23C. PHYSICIAN'S NAME (Type) Thomas J. Lai, Surgeon (R)									
23D. ADDRESS M.D. USPHS Hospital, Baltimore, Md.										24A. BURIAL CREMATION, REMOVAL (Specify) Burial									
24B. DATE 8/17/1965										24C. NAME of CEMETERY or CREMATORY Govans Presbyterian									
24D. LOCATION Baltimore, Md.										25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965									
25B. NAME OF REGISTRAR Robert E. Jenkins										25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd Balto. 12, Md.									

BIRTH NO. 65 8462		BALTIMORE CITY HEALTH DEPARTMENT		65 8462	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
		JAMES S. HINDLE		August 12, 1965 7:50 P	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		M.	
9-15-65		Maryland		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
Wooded area near Art Museum Dr.		Baltimore		7-04	
516 E. 27th Street and Charles St.		D. STREET ADDRESS (If rural, give location)		516 E. 27th Street	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Male	White	Married	12-5-1904	60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Foreman-Maintenance		Hospital		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Randolph Hindle		Mary Henderson		USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		213-07-5457		Laura E. Hindle Above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.0		Arteriosclerotic Heart Disease.			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) DUE TO			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22.		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from:		Yes	
		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (Type)		Charles S. Petty, M.D.		8/13/65	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY	
Burial		8-16-65		Moreland Memorial	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
AUG 16 1965		Robert E. Faldut		H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	

CERTIFICATE OF AWARD

1965

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8463				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8463	
M.E. CASE NO. 65 8463				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) NANCY E. FELTS				2. DATE AND HOUR OF DEATH August 14, 1965 5:50 p.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MONTEBELLO Hospital				A. STATE BALTIMORE B. COUNTY MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) 5209 Midwood Ave.			
				D. STREET ADDRESS (If rural, give location) 27-1D			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 6/15/1877		9. AGE (In years last birthday) 88	10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Mc BRIDE				14. MOTHER'S MAIDEN NAME MARY HAMPTON N.C.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-07-9846		17. INFORMANT MRS GERALDINE GEORGE ADDRESS SAME	
18. 491X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Aspiration				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) Branchopneumonia Rt. lung.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Lt. massive cerebral infarction 2 Rt. hemiplegia							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) (Yes)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 21 19 64 to August 14 19 65 , that (I) (we) lost saw the deceased alive on August 14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Fe U. Porciuncula				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 14, 1965	
23C. PHYSICIAN'S NAME (Type) Fe U. Porciuncula				23D. ADDRESS Montebello S. Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/18/1965		24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		24D. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Baltoll2, Md.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 65 8464	
BIRTH NO. 65 8464		CERTIFICATE OF DEATH		Registered No. 65 8464	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) PAUL B. WOLF		2. DATE AND HOUR OF DEATH 8/15/65 7:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3429 UNIVERSITY PLACE		D. STREET ADDRESS (If rural, give location) 3429 UNIVERSITY PLACE			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-12-1892	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER-CIVIL		10B. KIND OF BUSINESS OR INDUSTRY BALTO CITY		11. BIRTHPLACE (State or foreign country) GUNTHER, INDIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME LUTHER WOLF		14. MOTHER'S MAIDEN NAME ALICE BENNER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 214-463003		17. INFORMANT ADDRESS MRS. ELIZABETH V. WOLF - (SAME)	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Hemorrhage (B) Carcinoma of Hypopharynx (C)		INTERVAL BETWEEN ONSET AND DEATH 2 days 11 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1 1965 to Aug. 15 1965, that (I) (we) last saw the deceased alive on Aug. 13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Carleton C. Douglass M.D.		23B. DATE SIGNED 8/15/65		23C. PHYSICIAN'S NAME (Type) CARLETON C. DOUGLASS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/17/1965		24C. NAME OF CEMETERY or CREMATORY Druid Ridge	
24D. LOCATION Pikesville, Balto. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		25B. NAME OF REGISTRAR Robert E. Jankin	
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.					

1891

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Carter & Perkins
Carter & Perkins
8/10/91

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8465		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8465	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) John Freeman		2. DATE AND HOUR OF DEATH 8/15/65 1930 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Sp. Balto Gen. Hospital		A. STATE MD		B. COUNTY BALTO	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN BALTO		(If outside city limits, write RURAL and give township)	
		D. STREET ADDRESS 2707 Booker Drive #25			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	B. DATE OF BIRTH 8-23-03	9. AGE (In years last birthday) 61	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bethelham Red Emphy		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Prince George's Co., VA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ALBERT FREEMAN		14. MOTHER'S MAIDEN NAME ELMORA ELRIDGE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ALMA FREEMAN	
18. 331X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Intra cerebral Hemorrhage			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Essential Hypertension & Generalized arteriosclerosis			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 7-20-1965 to 8-15-1965, that (we) last saw the deceased alive on 8-15-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hugh J. Harnine				23B. DATE SIGNED 8-15-65	
23C. PHYSICIAN'S NAME (Type) Robert E. Taylor, M.D.				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-18-65		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION Md.		24E. NAME of REGISTRAR Robert E. Taylor, M.D.		24F. FUNERAL DIRECTOR E.O. Wilson	
24G. ADDRESS 1000 Brantley Ave.		24H. DATE REC'D BY HEALTH DEPT. AUG 16 1965		24I. NAME OF REGISTRAR Robert E. Taylor, M.D.	

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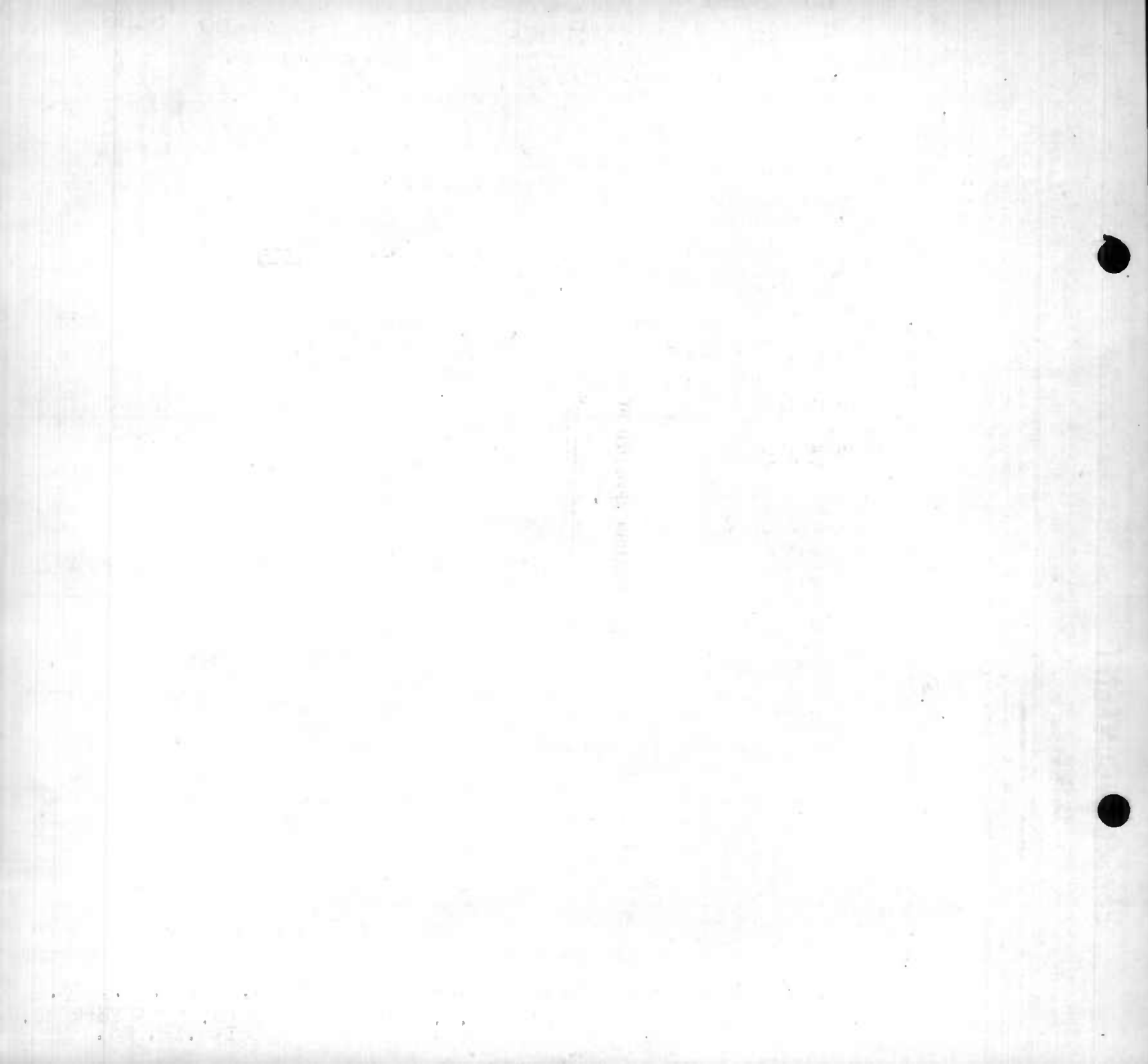
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH					Registered No. 65 8466						
BIRTH NO. 5432					M.E. CASE NO.						
1. NAME OF DECEASED (Type or Print) Thomas W. Shields					2. DATE AND HOUR OF DEATH 8/14/65 1:50 A.M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Accident Room Baltimore 18 Md					A. STATE Maryland, Baltimore Co.						
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Ruxton 5300						
					D. STREET ADDRESS (If rural, give location) 1806 Ruxton Rd						
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 1-29-12		9. AGE (In years lost birthday) 53			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales		10B. KIND OF BUSINESS OR INDUSTRY Standard Distiller		11. BIRTHPLACE (State or foreign country) Alaska		12. CITIZEN OF WHAT COUNTRY? USA.					
13. FATHER'S NAME Walter Shields					14. MOTHER'S MAIDEN NAME Julia Kenly						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII					16. SOCIAL SECURITY NO. BY M.		17. INFORMANT Philip L. Shields				
					ADDRESS Above						
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH Myocardial infarction Coronary occlusion Arteriosclerotic Cardiovascular disease					INTERVAL BETWEEN ONSET AND DEATH sudden	
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 8-14 1965 to 8-14 1965, that (I) (we) last saw the deceased alive on DOA 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Alex G. Ossman Jr					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-14-65				
23C. PHYSICIAN'S NAME (Type) Alex G. Ossman Jr					M.D.		23D. ADDRESS 1010 St Paul St Balto 2 Md				
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/18/1965		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12, Md.					

Released by medical examiner on approval



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8467				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8467	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Davis, Robert Lee</i>				2. DATE AND HOUR OF DEATH <i>8/13/65</i> <i>9:10 a.m.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Montebello State Hospital</i>				A. STATE <i>Maryland</i> B. COUNTY <i>23-01</i>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				D. STREET ADDRESS (If rural, give location) <i>932 S. Hanover St.</i>			
5. SEX <i>male</i> 6. RACE <i>negro</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>				8. DATE OF BIRTH <i>4-30-01</i> AGE (In years last birthday) <i>64</i>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labourer</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				13. FATHER'S NAME <i>Theodore Davis</i>			
14. MOTHER'S MAIDEN NAME <i>unknown</i>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			
16. SOCIAL SECURITY NO. <i>211-11-1111</i>				17. INFORMANT ADDRESS <i>Hospital Records</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <i>420.1 I</i> <i>212-14-8070</i> (A) <i>arteriosclerotic heart disease</i> <i>due to</i> <i>myocardial infarction +</i> (B) <i>congestive failure</i> <i>due to</i> (C)			
INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>6/2/65</i> 19 to <i>8/13/65</i> 19 that (I) (we) last saw the deceased alive on <i>8/13/65</i> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Daniel G. Lai</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8/13/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Daniel G. Lai</i>				23D. ADDRESS M.D. <i>330 Argonne Dr. Baltimore 18, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/17/65</i>		24C. NAME of CEMETERY or CREMATORY <i>Carver Memorial Park</i>		24D. LOCATION (City, town, or county) (State) <i>Laurel Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 17 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Charles A. Rice</i>		ADDRESS <i>661 W. Barre St</i>	

vs 153 signed by funeral director

65 8468		BALTIMORE CITY HEALTH DEPARTMENT		65 8468	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		JONATHAN OLIVER		2. DATE AND HOUR PRONOUNCED DEAD August 12, 1965 2:30 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 2211 Eutaw Place		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		13-02	
		D. STREET ADDRESS (If rural, give location) 2211 Eutaw Place			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12/9/39	9. AGE (In years last birthday) 24	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Louis Oliver		14. MOTHER'S MAIDEN NAME Katherine Fletcher	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-34-9216		17. INFORMANT Katherine Oliver 1134 Wilmer Ct.	
18. E981X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) Gunshot Wounds of Chest. DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2211 Eutaw Place	
21D. TIME OF INJURY (APPROX.) 8 12 '65 Noon		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Shot during altercation.	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 8/16/65		23C. NAME of CEMETERY or CREMATORY Baltimore National	
23D. LOCATION Baltimore, Maryland		23E. DATE REC'D BY HEALTH DEPT. AUG 17 1965		23F. NAME OF REGISTRAR Robert E. Farley, M.D.	
23G. FUNERAL DIRECTOR Charles A. Rice 661 W. Barre St.		23H. ADDRESS		23I. DATE SIGNED 8/12/65	

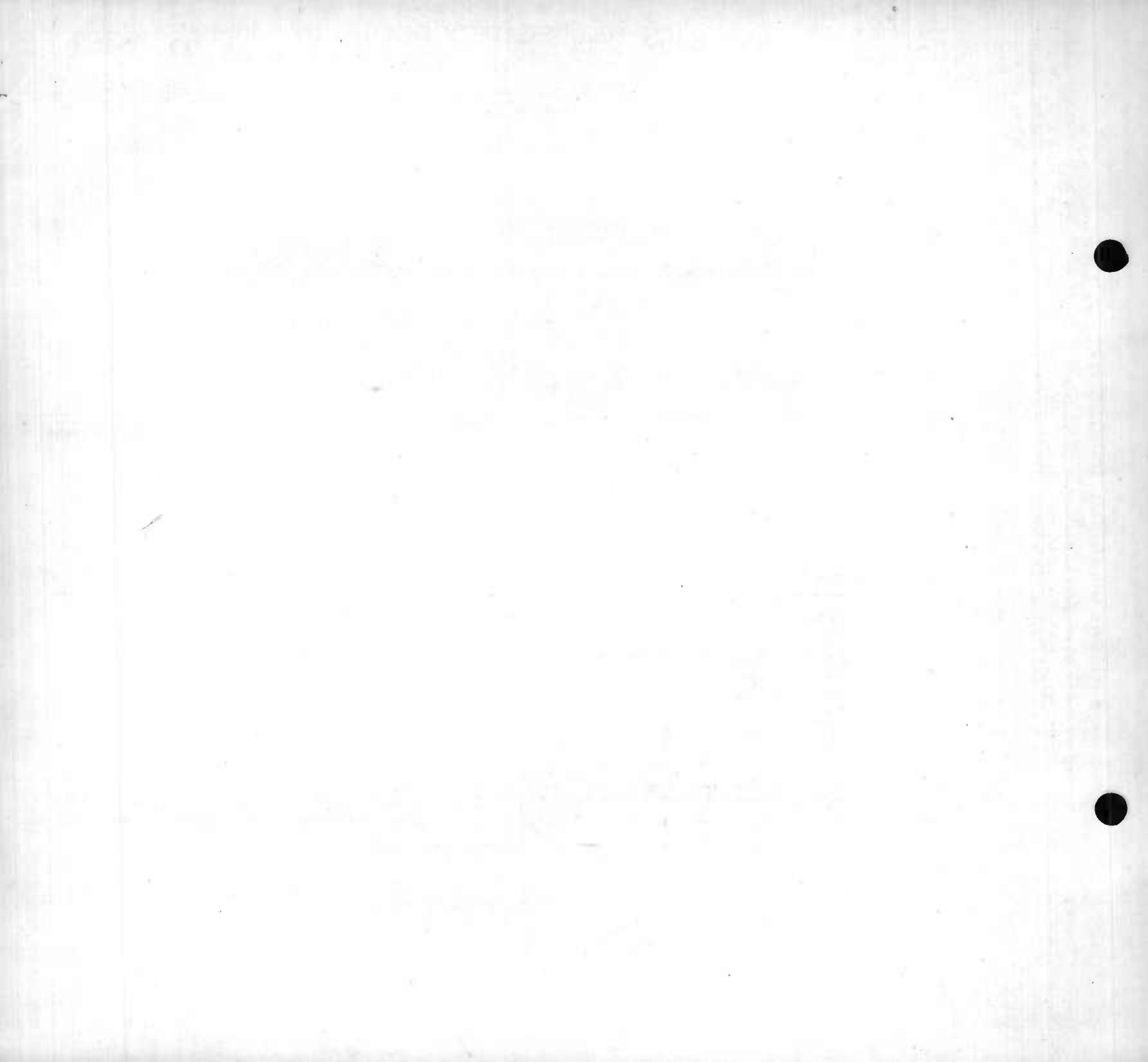
WALLACE BONDING

WAS COAST GUARD

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT										Registered No. <u>528 053.</u>	
BIRTH NO. <u>65 8469</u>		CERTIFICATE OF DEATH						65 8469		415 A. M.	
1. NAME OF DECEASED (Type or Print) <u>BABY GIRL PEAKE</u>										2. DATE AND HOUR OF DEATH <u>6 AUG 65</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNION MEMORIAL HOSPITAL</u>					A. STATE <u>MD</u> B. COUNTY <u>18</u>						
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					D. STREET ADDRESS (If rural, give location) <u>9-06</u>						
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>N.M.</u>		8. DATE OF BIRTH <u>5 AUG 65</u>		9. AGE (In years last birthday) <u>17 hours</u>		If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min. <u>17</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>RICHARD PEAKE</u>						14. MOTHER'S MAIDEN NAME <u>SCARLETT ROSE</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>N</u>		17. INFORMANT ADDRESS					
18. <u>75-9.01</u> CAUSE OF DEATH										INTERVAL BETWEEN ONSET AND DEATH <u>17 hours</u>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH										(A) <u>HYPOPLASTIC LUNGS</u>	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)										(B) <u>PREMATURITY</u>	
ANTECEDENT CAUSES										(C)	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <u>0 NONE</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>8-5</u> 19 <u>65</u> to <u>8-6</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>8-6</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did not) view the body after death.											
23A. SIGNATURE <u>John Rowse</u>								M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8-6-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOHN ROWSE</u>								23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>AUG 16 1965</u>				24B. DATE				24C. NAME OF CEMETERY OR CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD</u>			
24D. LOCATION (City, town or county) (State)				24E. DATE REC'D BY HEALTH DEPT. <u>AUG 17 1965</u>				24F. NAME OF REGISTRAR <u>Robert E. Fairley</u>			
24G. FUNERAL DIRECTOR ADDRESS				24H. NAME OF REGISTRAR				24I. NAME OF REGISTRAR			



A-5531
On page after give permission to Dr. Hendry to do post
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8470	
BIRTH NO. 65-18546		65 8470		CERTIFICATE OF DEATH	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Baby Kiel Hammond</i>			7-27-65 18 ³⁰ am M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>7 Mercy Hospital</i>			A. STATE <i>md</i> B. COUNTY <i>14-02</i>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto</i>		
			D. STREET ADDRESS (If rural, give location) <i>1402 Druid Hill Drive</i>		
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>7-24-65</i>	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <i>Balto md</i>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Roland Hammond</i>			14. MOTHER'S MAIDEN NAME <i>Olivia Bernard</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Congenital Heart Disease</i> <i>Aplastic (L) ventricle</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Life</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Cerebral Hemorrhage</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7/24</i> 19 <i>65</i> to <i>7/27</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>7/27</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>W. E. Hendry</i>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7/29/65</i>
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>AUG 16 1965</i>		24C. NAME of CEMETERY or CREMATORY <i>JOHNS HOPKINS MEDICAL SCHOOL</i>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 17 1965</i>			
25B. NAME OF REGISTRAR <i>Roland E. Finkbeiner</i>		25C. FUNERAL DIRECTOR <i>MORTUARY SERVICE - BCHD</i>		ADDRESS	

✓
1/92/02

1/91

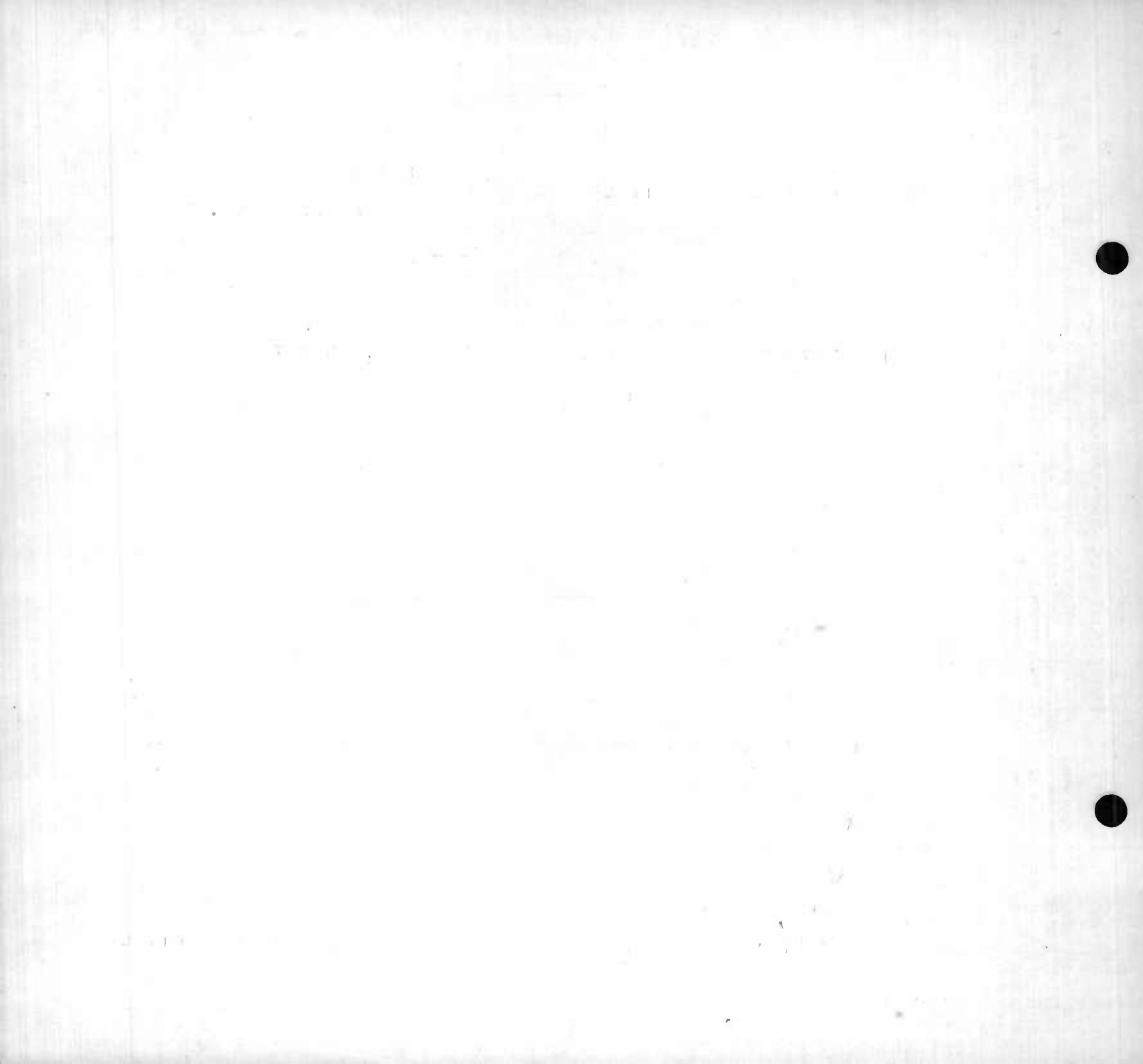
1/91

1/92/02

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

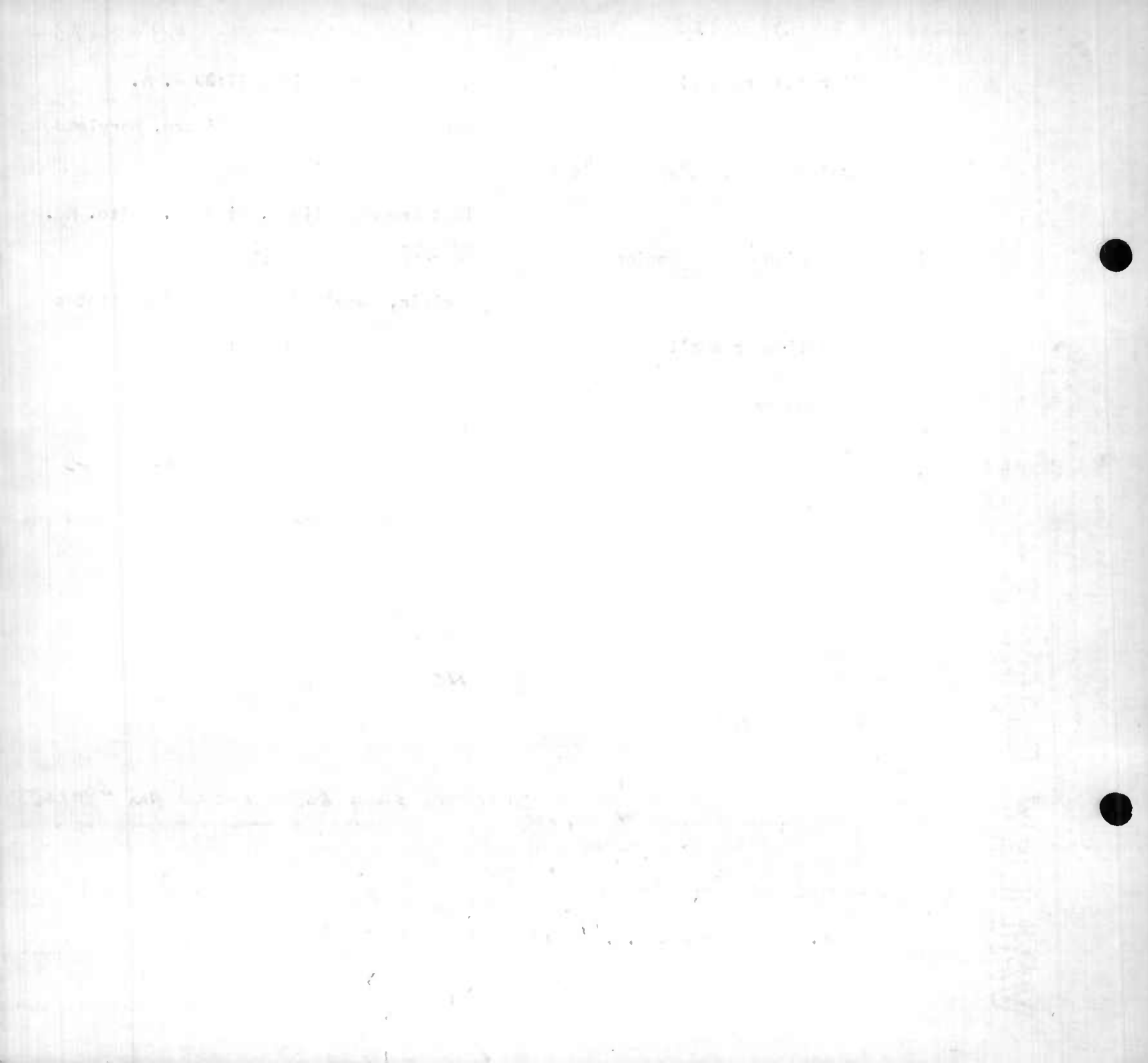
BIRTH NO. 65 8471		CERTIFICATE OF DEATH		Registered No. 65 8471	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Greengot, Sonia		2. DATE AND HOUR OF DEATH 8/12/65 1235p M.	
3. PLACE OF DEATH IN BALTIMORE MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 15-38 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3405 POWHATTEN AVE.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 6-8-03	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME DAVID HARTMAN		14. MOTHER'S MAIDEN NAME CLARA PEARLMUTTER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Coronary arrest DUE TO (B) Acute Myocardial Infarction DUE TO (C) Coronary arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 0 48 hr -	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-11-65 19 to 8-12-65 19, that (I) (we) last saw the deceased alive on 8-12-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joel F. Habener		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-12-65	
23C. PHYSICIAN'S NAME (Type) JOEL F. HABENER		23D. ADDRESS The Johns Hopkins Hospital UNIVERSITY MEDICAL SCHOOL			
24A. BURIAL CREMATION, REMOVAL (Specify) AUG 16 1965		24B. DATE		24C. NAME OF CEMETERY or CREMATORY MORTUARY SERVICE - BCHD	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. AUG 17 1965			
25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8472				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8472	
1. NAME OF DECEASED (Type or Print) Clarence Creswell				2. DATE AND HOUR OF DEATH 5 August 1965 12:00 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland Penitentiary Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Last known B. COUNTY Baltimore, Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore City 4-02			
				D. STREET ADDRESS (If rural, give location) last known 116 N. Pine St. Balto. Md.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Denies	8. DATE OF BIRTH 9/20/05	9. AGE (In years lost birthday) 59	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Belair, Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME William Creswell				14. MOTHER'S MAIDEN NAME Dora Dolan			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Denies		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. 332X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 12 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO Arteriosclerosis		more than 1 year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C)		None known -	
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3:30 PM 3 Aug 1965 to 12:20 AM 5 Aug 65 , that (I) (we) last saw the deceased alive on 4 Aug 65 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Conrad Acton				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5 Aug 65	
23C. PHYSICIAN'S NAME (Type) Dr. Conrad Acton, M.D.				23D. ADDRESS Maryland Penitentiary			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE AUG 10 1965		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD			



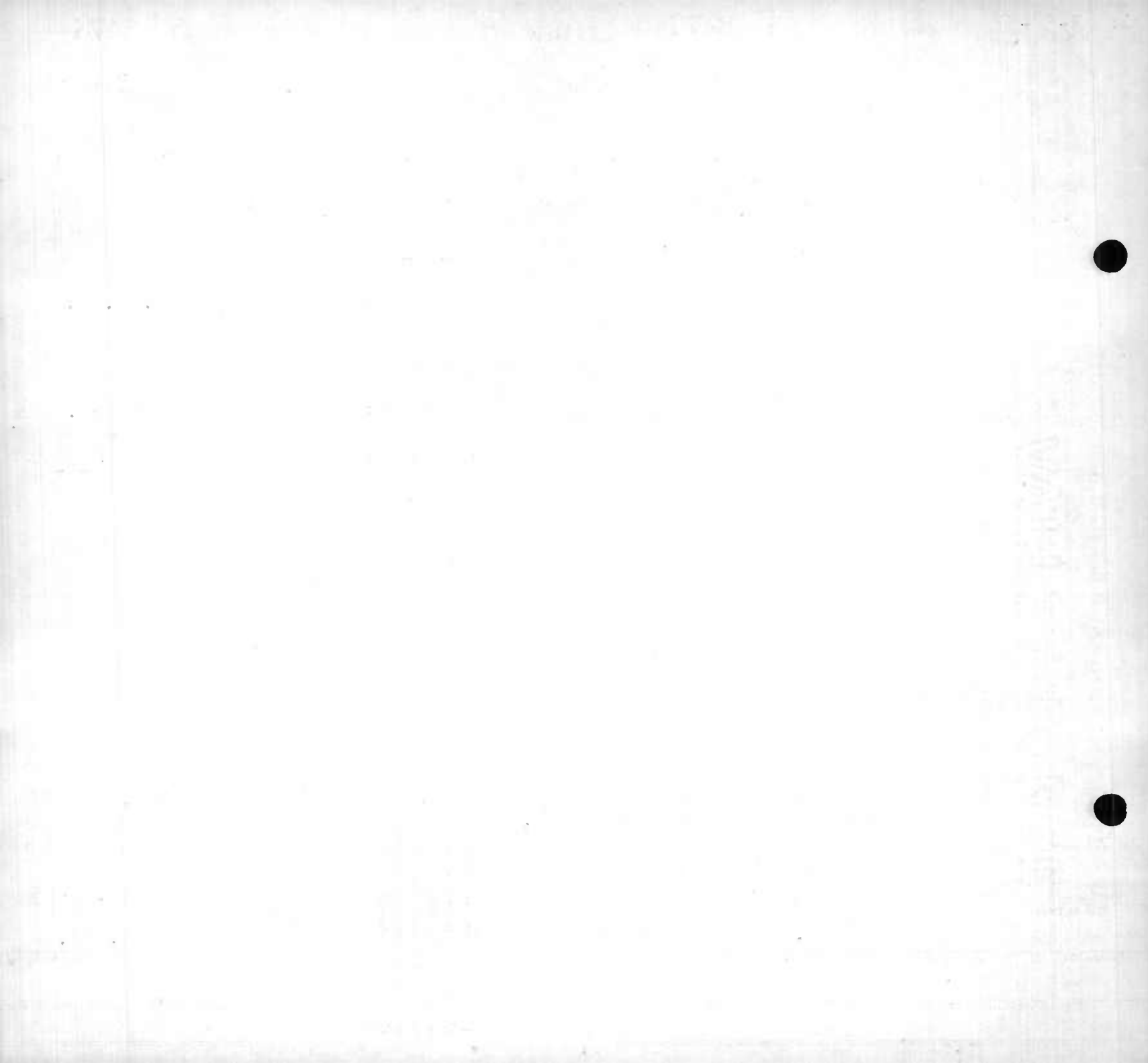
IS: 43-68-53

H-624

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

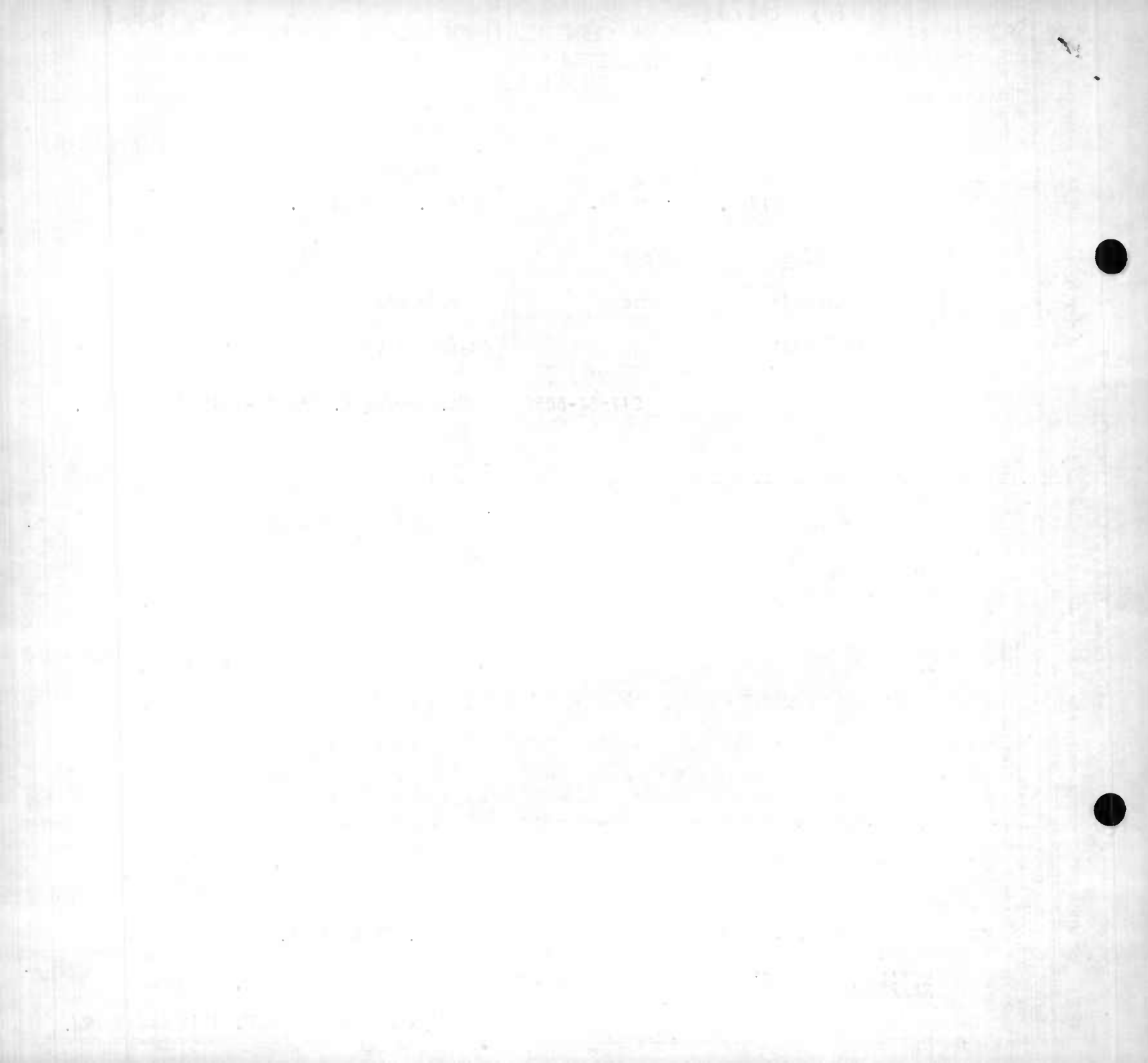
BIRTH NO. 65 8473				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8473	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Walter Horsley				2. DATE AND HOUR OF DEATH August 4, 1965 3:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY 10-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1404 Hempel Court #21202			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 3-22-14	9. AGE (In years last birthday) 51	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS RECORDS: BCH: 4940 Eastern Ave. #24	
18. 352X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Spastic Paresis (R) Arm and (L) Arm and Paralysis of Legs ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Decubitus Ulcers				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Since 4-2-65	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 24, 1965 to August 4, 1965 , that (I) (we) last saw the deceased alive on August 4, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. Donald Baltzan				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 4, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. Donald Baltzan				23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. #24			
24A. BURIAL CREMATION, REMOVAL (Specify) AUG 16 1965		24B. DATE		24C. NAME OF CEMETERY or ANATOMY BOARD OF MARYLAND		24D. LOCATION (City, town or square) (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCH			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8474				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8474	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SADIE J. CROCKIN				2. DATE AND HOUR OF DEATH 8/13/65 16:15 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Stafford Hotel 714 N. Charles ST.				A. STATE Maryland B. COUNTY 11-02			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 714 N. Charles St.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH	9. AGE (In years lost birthday) 85	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isaac Jacobs				14. MOTHER'S MAIDEN NAME Annie Levin			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-22-6059		17. INFORMANT ADDRESS Mr. Irving C. Grant -1045 Taylor Ave.			
18. 350X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Parkinson's Disease (A) DUE TO Coronary insufficiency (B) DUE TO (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH 8 years 1953			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 1943 to Aug 12 1965 , that (I) (we) last saw the deceased alive on Jan 1943 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Samuel Whitehouse				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/14/65	
23C. PHYSICIAN'S NAME (Type) Samuel Whitehouse				23D. ADDRESS 3900 N. Charles ST.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/15/65		24C. NAME OF CEMETERY OR CREMATORY Hebrew Friendship		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1965		25B. NAME OF REGISTRAR Robert E. Talbot		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS INC. 6010 Reist Rd.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8475				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8475	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
1731 Park Avenue				Maryland		14-01	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				D. STREET ADDRESS (If rural, give location)			
				1731 Park Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
Male	White	Divorced	Dec 25, 1884	80			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Tailor		Shop		Baltimore, Md		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Salomon Fink				Cecelia ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No						Melvin J. Fink - 2224 Park Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
163X I				(A) Carcinoma of lung.		3 mo.	
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				A - 5 heart disease		3 yr.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (the health official) attended the deceased from 4/18 1962 to 8/15 1965, that (I) (we) last saw the deceased alive on 8/9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE, SIGNED			
N. R. Freeman Jr.				8/16/65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
N. R. FREEMAN JR.				11 W. 29th St.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/16/65		Baltimore Hebrew		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 17 1965		Robert S. Freeman		Sal. Freeman & Pate		6000 Reister Rd	

Carroll County

A-2 Hunt

8/12

8/10/07

11 W. 2nd St

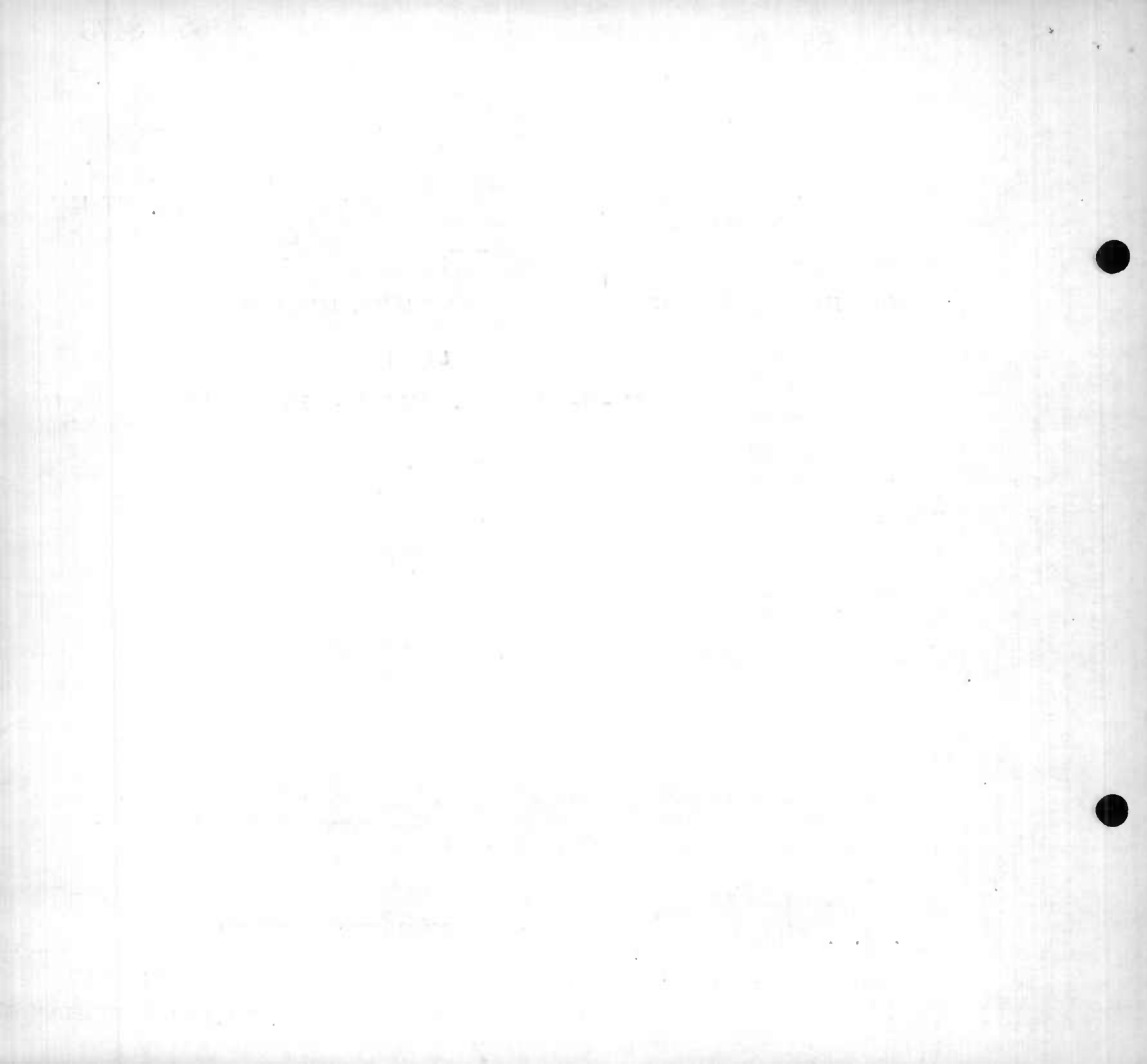
James L. Freeman

11 W. 2nd St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

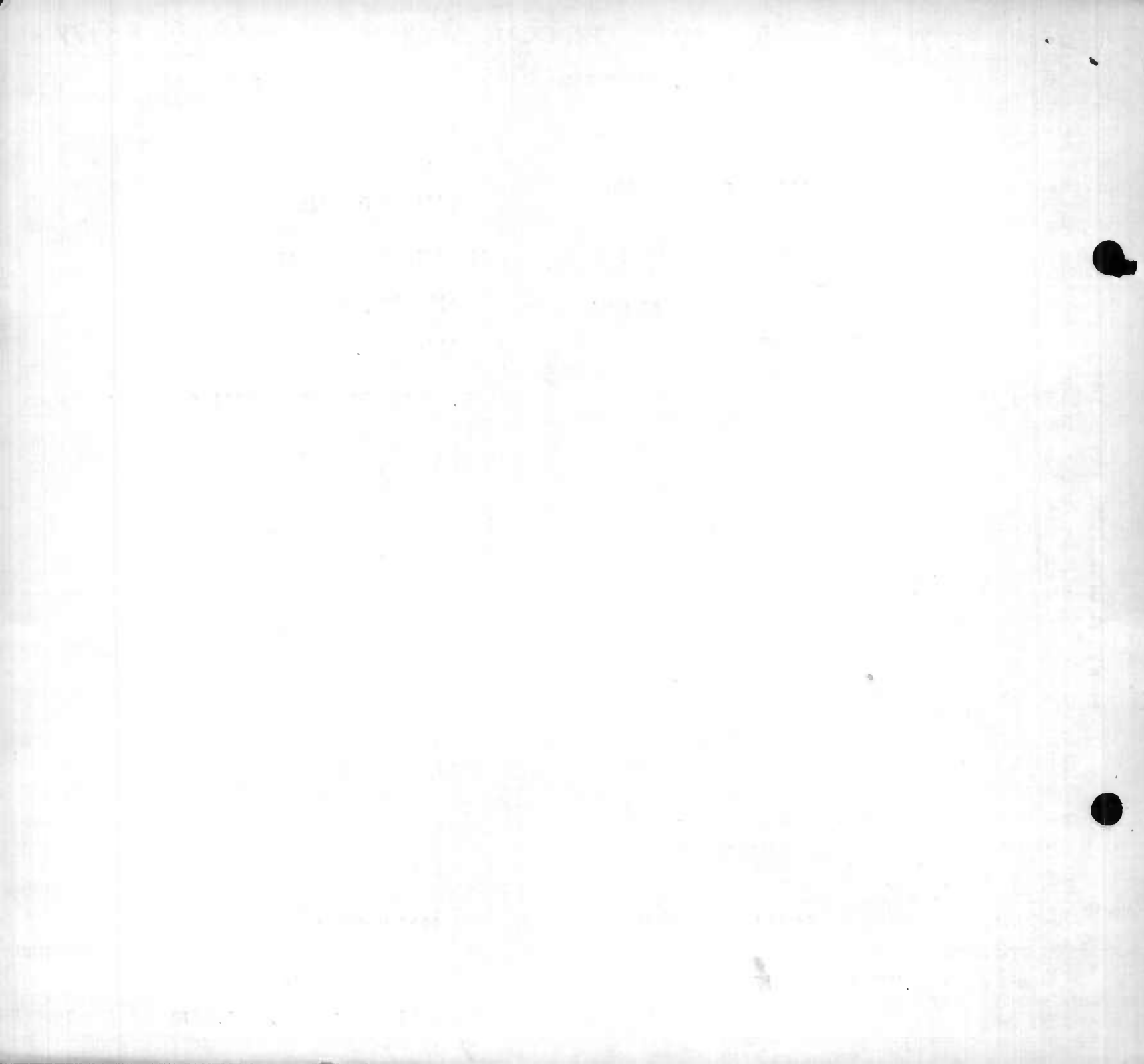
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8476	
BIRTH NO. 65 8476 K.		CERTIFICATE OF DEATH		1. NAME OF DECEASED (Type or Print) JOSEPHINE PIMES	
2. DATE AND HOUR OF DEATH 8-16-65 3.15 A.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3 JOHNS HOPKINS HOSPITAL			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 13-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 21 2601 Madison Ave D. STREET ADDRESS (If rural, give location) TEMPLE GARDEN APTS. APT 1206		5. SEX FEMALE 6. RACE WHITE 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW			
8. DATE OF BIRTH 8-4-98 9. AGE (In years last birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) NEW ORLEANS, LOUISIANA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME LAMBERT KUHN		14. MOTHER'S MAIDEN NAME BILLIE HABER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-01-3545		17. INFORMANT ADDRESS MRS. MILTON FOX 3900 N CHARLES ST APT 1206	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ventricular Fibrillation DUE TO Myocardial Infarction DUE TO DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. INTERVAL BETWEEN ONSET AND DEATH 1 hr. 15 min.				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION 19 65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from July 30 to August 16 19 65, that (1) (we) last saw the deceased alive on August 16 19 65 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J.P. Caulfield				23B. DATE SIGNED 8/16/65	
23C. PHYSICIAN'S NAME (Type) DR. J.P. CAULFIELD		23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/17/65		24C. NAME of CEMETERY or CREMATORY HEBREW FRIENDSHIP	
24D. LOCATION BALTIMORE		24E. (City, town, or county) MARYLAND (State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

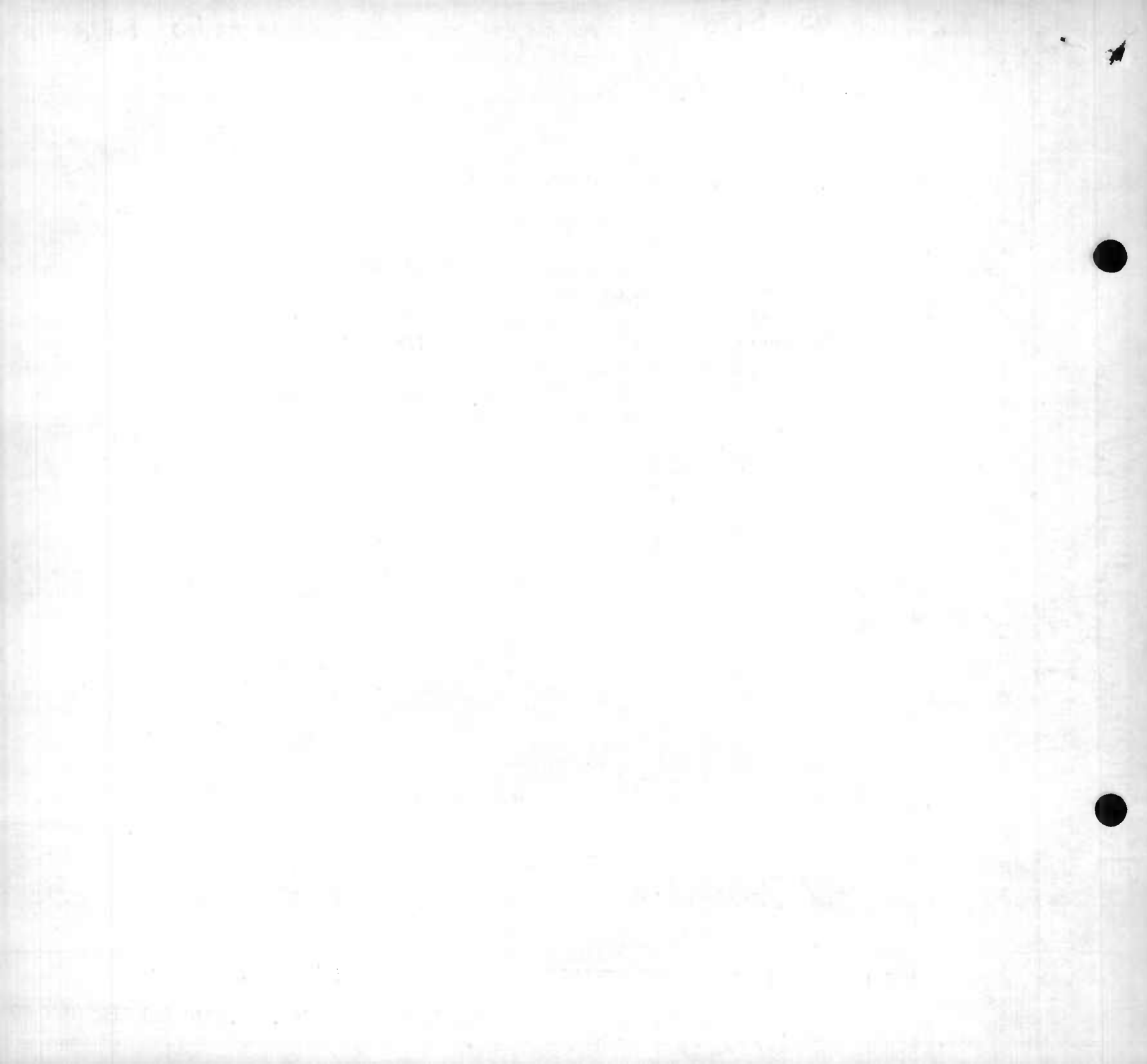
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8477	
BIRTH NO. 65 8477		CERTIFICATE OF DEATH		Registered No. 65 8477	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CECILIA A. ROSENBERG		2. DATE AND HOUR OF DEATH AUGUST 15, 1965 9 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2111 CARTERDALE ROAD		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2111 CARTERDALE ROAD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10/27/1907	9. AGE (In years lost birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME CHARLES ABRAMSON			14. MOTHER'S MAIDEN NAME FLORA LEVIN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS MR. JESSE ROSENBERG 2111 CARTERDALE ROAD		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 153.3 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Carcinoma of sigmoid with metastases. DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Diagnosed April 1965	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION April 16/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Sigmoid		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 1965 to August 15, 1965, that (I) (we) lost saw the deceased alive on Aug. 14, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Samuel Whitehouse		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/15/65	
23C. PHYSICIAN'S NAME (Type) SAMUEL WHITEHOUSE		23D. ADDRESS M.D. 3900 N CHARLES ST			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 8/17/65	24C. NAME OF CEMETERY OR CREMATORY AITZ CHAIM		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 65 8478	
BIRTH NO. 65 8478		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) KORMAN, LOUIS		2. DATE AND HOUR OF DEATH AUG. 15, 1965 4:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE		A. STATE MARYLAND B. COUNTY BALTIMORE			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 5300			
		D. STREET ADDRESS (If rural, give location) 3516 MARYVALE RD #7			
5. SEX MALE	6. RACE CAUC	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUTCHER		10B. KIND OF BUSINESS OR INDUSTRY STORE		11. BIRTHPLACE (foreign country) RUSSIA	
13. FATHER'S NAME DAVID KORMAN		14. MOTHER'S MAIDEN NAME FREIDA ?		12. CITIZEN OF WHAT COUNTRY? U.S.A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MR. GEORGE JACOBS 3516 MARYVALE ROAD	
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Lung CARCINOMA		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from AUG. 14, 1965 19 to AUGUST 15 19 65 , that (I) (we) last saw the deceased alive on AUGUST 15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Herbert Fellerman		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Aug. 15, 1965	
23C. PHYSICIAN'S NAME (Type) HERBERT FELLERMAN		M.D.		23D. ADDRESS SINAI HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/16/65		24C. NAME OF CEMETERY or CREMATORY BETH TFILOH	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. AUG 17 1965			
25B. NAME OF REGISTRAR Q. C. B. E. Fellerman		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD			



Body released by the approval of medical Examiner Mr. Henry.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8479		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8479	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) Lerch, Charles Sebastian		
2. DATE AND HOUR OF DEATH Aug. 15, 1965, 4:45 a. M.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00		
D. STREET ADDRESS (If rural, give location) 7817 Overbrook Rd.			FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp 33 rd 1 Calvert St. Baltimore, Md. 21218		
5. SEX Male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1-31-92	9. AGE (In years lost birthday) 73	10. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) attorney		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles E. Lerch			14. MOTHER'S MAIDEN NAME Emma Robinson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Ante renal failure			INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Severe burns over 75% body area.			20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
21. MEDICAL CERTIFICATION 19A. DATE OF OPERATION (Month) (Day) (Year) (Hour) Aug-13-65 3:00 PM 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED (venous cut down) 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) yes notify Med. Examiner 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) In home 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Burned at home 7817 Overbrook Rd 21D. TIME OF INJURY (APPROX.) Aug-13-65 3:00 PM 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> 21F. HOW DID INJURY OCCUR? pajama got burned 22. I certify that (H) (this hospital) attended the deceased from Aug. 13 to Aug. 15, 1965, that (H) (we) lost saw the deceased alive on Aug. 15, 1965, and that (H) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.			23. SIGNATURE KANG FAN, 23B. DATE SIGNED Aug-15-65 23C. PHYSICIAN'S NAME (Type) KANG FAN, 23D. ADDRESS Union Memorial hospital Baltimore, Maryland 21218		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-17-65		24C. NAME of CEMETERY or CREMATORY Greenmount	
24D. LOCATION Baltimore		25A. DATE REC'D BY HEALTH DEPT. AUG 17 1965		25B. NAME OF REGISTRAR H.W. Mears + Son	
25C. FUNERAL DIRECTOR ADDRESS 805 N. Calvert St.		25D. ADDRESS			

THE END

1		65 8480		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 8480	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) EDWARD J. KELLY				2. DATE AND HOUR PRONOUNCED DEAD August 12, 1965 6:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 311 S. Sharpe Street				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7201 D. STREET ADDRESS (If rural, give location) 311 S. Sharpe Street			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never married		8. DATE OF BIRTH 12-25-1908	9. AGE (In years last birthday) 56	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handy Man	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handy Man				11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas Kelly				14. MOTHER'S MAIDEN NAME Catherine Murray			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War 2				16. SOCIAL SECURITY NO. 218-10-4097		17. INFORMANT ADDRESS Miss Mary E. Doxzen, 410 E. 28th St. Balto.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease. DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Petty, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/13/65							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 8-17-65		23C. NAME of CEMETERY or CREMATORY Balto. National Cemetery		23D. LOCATION (City, town, or county) (State) Frederick Ave., Balto. Md.	
24A. DATE REC'D BY HEALTH DEPT. AUG 17 1965		24B. NAME OF REGISTRAR Robert E. Ferguson		24C. FUNERAL DIRECTOR ADDRESS Flynn & Fleming, 1422 Light St. Balto.			

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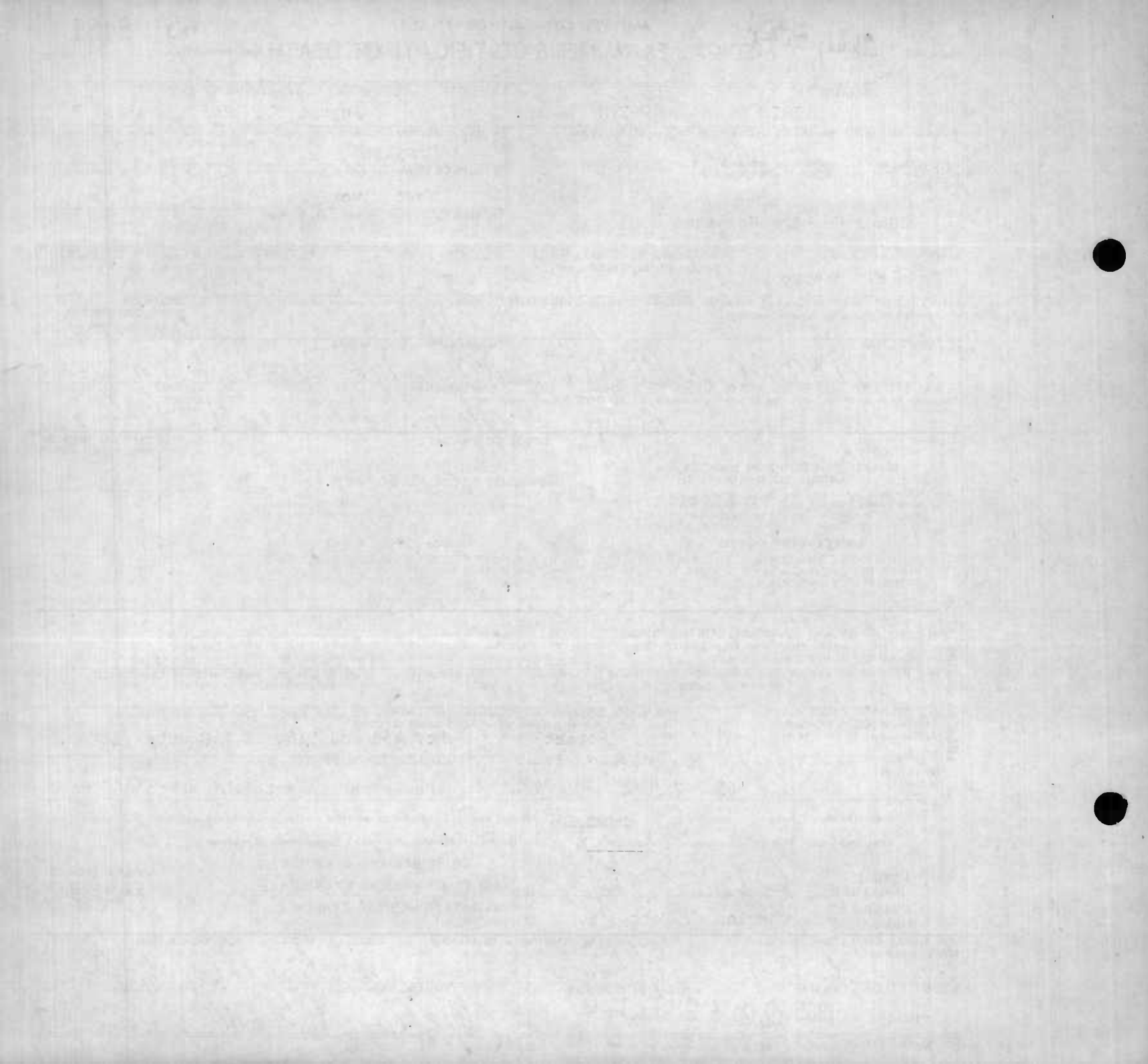
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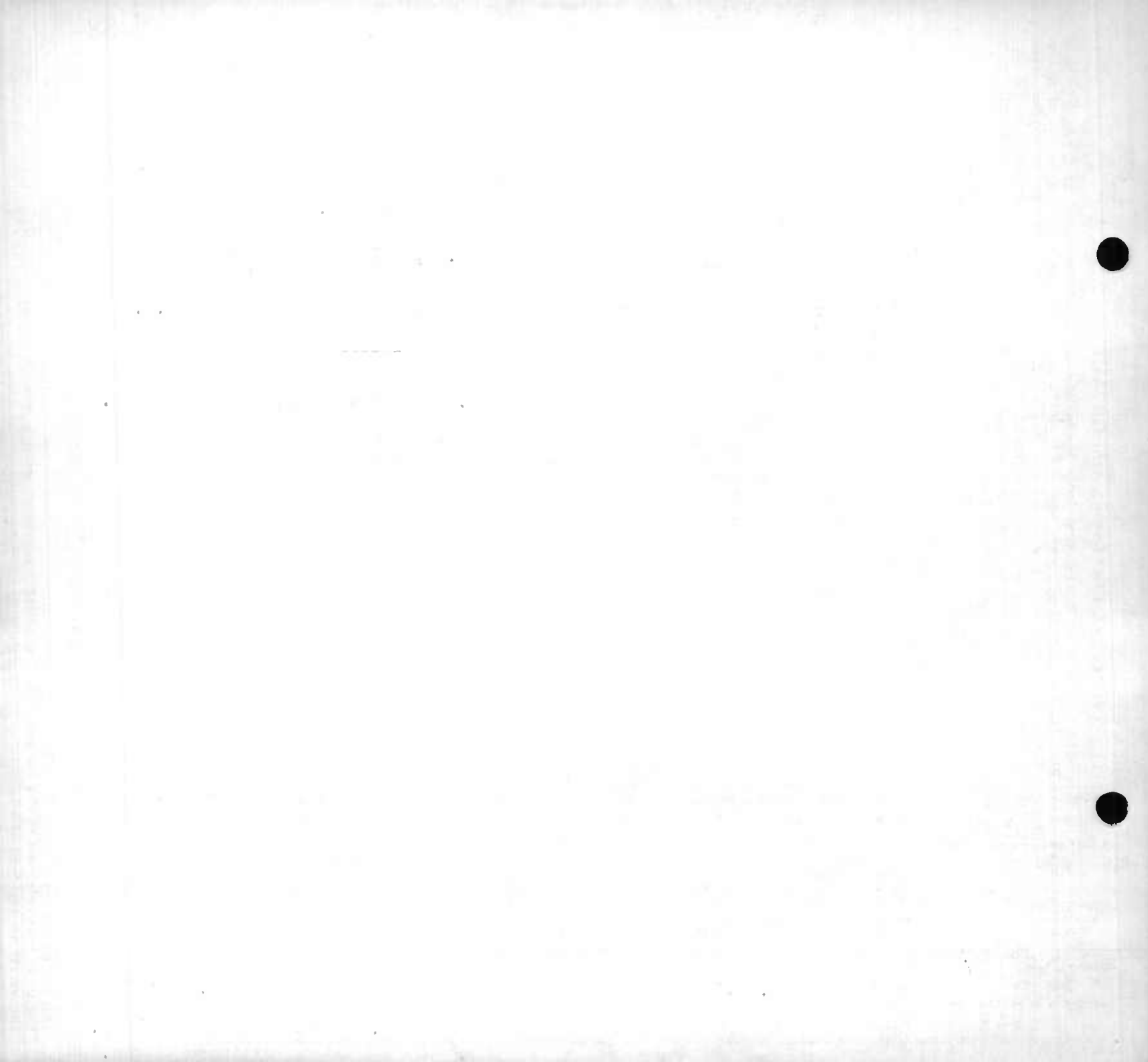
BIRTH NO. <i>65 8481</i>		BALTIMORE CITY HEALTH DEPARTMENT		65 8481	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		IRIS		WHITE	
2. DATE AND HOUR PRONOUNCED DEAD		August 12, 1965		4:45 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland	
Johns Hopkins Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		West River	
D. STREET ADDRESS (If rural, give location)		62-00			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.
Female	Negro		1-30-1959	6	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Norman White		Mary Margaret Worsley		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Norman White West River Md.	
18. <i>E 8234</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Craniocerebral Injury.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		Street		Rt. 468 and 214, A.A. County	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Passenger in auto which ran off roadway	
8 11 '65 P.m.					
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type)		Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
Burial		8-15-65		Ebezer	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR	
AUG 17 1965		Robert E. Farber, M.D.		William Reese # Anna, Md.	
				ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

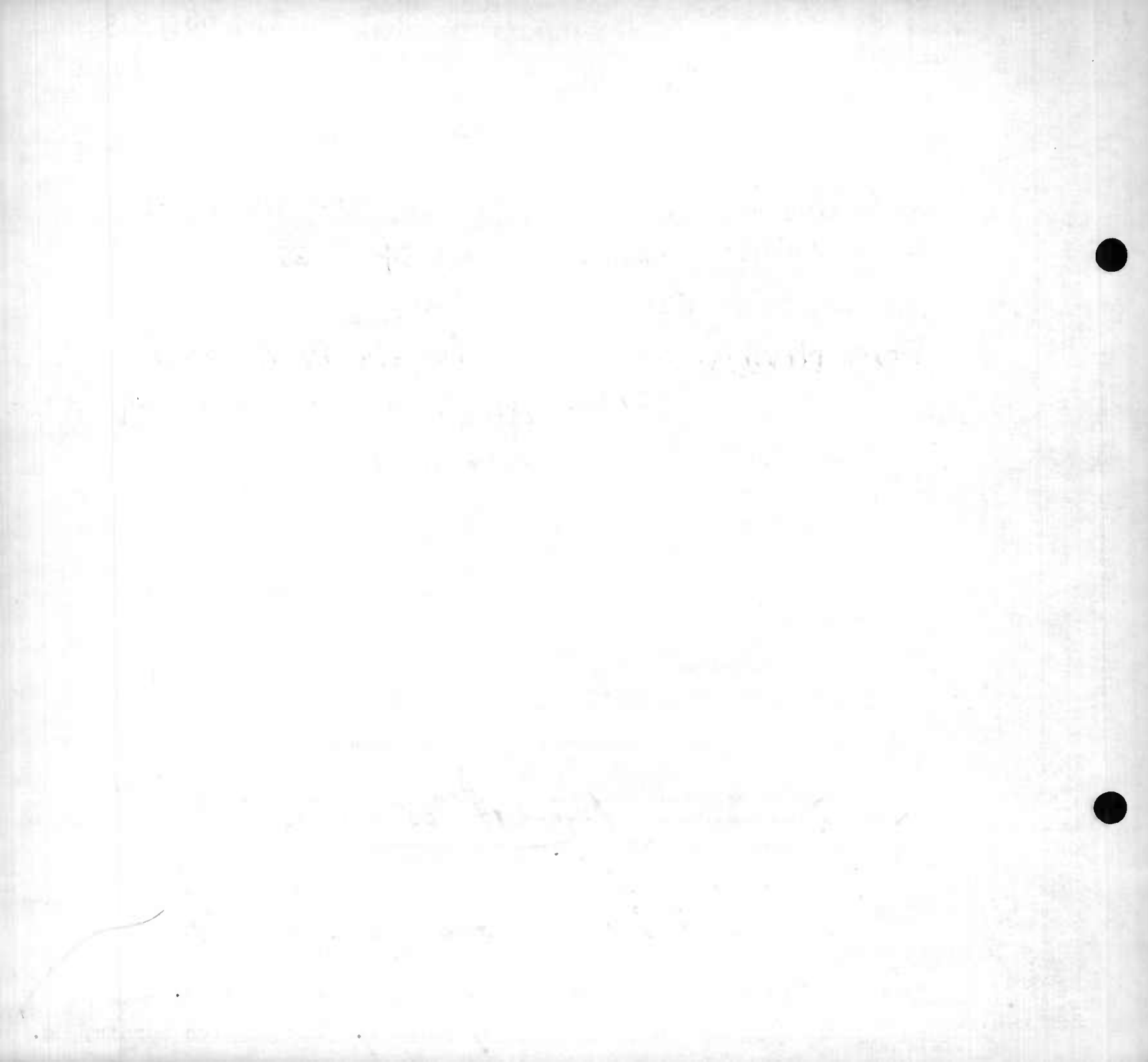
BALTIMORE CITY HEALTH DEPARTMENT									
65 8482					BIRTH NO.				
65 8482					Registered No.				
CERTIFICATE OF DEATH									
1. NAME OF DECEASED (Type or Print) John Gabis					2. DATE AND HOUR OF DEATH August 10, 1965 3:30 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 25-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) 302 Jeffrey St.				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH Sept. 22, 1902	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter		10B. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Anne -----					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Catherine Gabis, 302 Jeffrey St.			
18. 4-20-01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO		(B) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					(C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that he (this hospital) attended the deceased from 4-3-1965 to 4-21-1965 , that (I) last saw the deceased alive on 7-26-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Kermit P. Bonovich M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED				
23C. PHYSICIAN'S NAME (Type) Kermit P. Bonovich M.D.					23D. ADDRESS So. Balto. Gen. Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 14, '65		24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR ADDRESS George J. Gonce, 4001 Ritchie Hwy. Baltimore 25, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8483	
BIRTH NO.		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH 8/14/65 1:40 PM	
M.E. CASE NO.		1. NAME OF DECEASED PISCOLLA, Mr. Louis		2. DATE AND HOUR OF DEATH 8/14/65 1:40 PM	
1. NAME OF DECEASED (Type or Print)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTO.	
FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS HOSPITAL		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	
8. DATE OF BIRTH 12/8/84		9. AGE (In years last birthday) 80		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY CLOTHING		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? ITALY		13. FATHER'S NAME FERDINAND PISCOLLA		14. MOTHER'S MAIDEN NAME Angela M. Palmieri	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-03-0721		17. INFORMANT FERNON BASSO - 612 N. GAYLOR AVE.	
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Arteriosclerotic Heart Disease DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from August 13 1965 to August 14 1965 , that (X) (we) lost saw the deceased alive on August 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alexander R. Lim		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 14, 1965	
23C. PHYSICIAN'S NAME (Type) Alexander R. Lim		M.D. ADDRESS BON SECOURS Hosp. Balto. 23			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/17/65		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. AUG 17 1965		24F. NAME OF REGISTRAR Robert E. Fink	
24G. FUNERAL DIRECTOR Raymond C. Fink		24H. ADDRESS Glen Burnie, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8484				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8484			
1. NAME OF DECEASED (Type or Print) HAROLD C. SHARP				2. DATE AND HOUR OF DEATH AUG 14 1965 4:20 AM							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 18-03							
5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED				8. DATE OF BIRTH 8-2-01 9. AGE (in years last birthday) 64							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK (RET)				11. BIRTHPLACE (State or foreign country) VIRGINIA							
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME SAMUEL SHARP				14. MOTHER'S MAIDEN NAME Does not remember Jane Spring							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 2/26/31-11/20/33				16. SOCIAL SECURITY NO. 218-12-0892							
17. INFORMANT Sciba B. SHARP				ADDRESS 1148 W. Lombard St							
18. 401.0 I				CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) pulmonary edema DUE TO							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) congestive heart failure DUE TO							
				(C) massive myocardial infarction fibrinous pericarditis							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 8-5-1965 to 8-14-65 19 that (I) (we) last saw the deceased alive on 8-14-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Jaime V. Del Pilar				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED					
23C. PHYSICIAN'S NAME (Type) JAIME V. DEL PILAR				23D. ADDRESS FRANKLIN SQUARE HOSPITAL							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/17/65		24C. NAME of CEMETERY or CREMATORY Balto. National Cem.		24D. LOCATION (City, town, or county) (State) Balt. more - Md					
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Walters Funeral Home		ADDRESS Tratt & Strickel St.					

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BALTIMORE CITY HEALTH DEPARTMENT

65 8485

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES HILL

2. DATE AND HOUR PRONOUNCED DEAD

8-15-65

11:40 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

SOUTH BALTIMORE GENERAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

District of Columbia

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Washington

D. STREET ADDRESS (If rural, give location)

2505 "N" Street, S.E.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Never married

8. DATE OF BIRTH

2/16/1916

9. AGE (In years
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Construction work

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James M. Hill

14. MOTHER'S MAIDEN NAME

Agnes A. Boarman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL
SECURITY NO.

577 12 1102

17. INFORMANT

ADDRESS

J. Carl Hill Bro. Woodbridge, Va.

18.

420.11

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive and arteriosclerotic
DUE TO
XXXX

cardiovascular disease with recent

(B) and old coronary occlusion
DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-16-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/19/65

23C. NAME OF CEMETERY or CREMATORY

Cedar Hill Cem.

23D. LOCATION

(City, town, or county)

(State)

Suitland, Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 17 1965

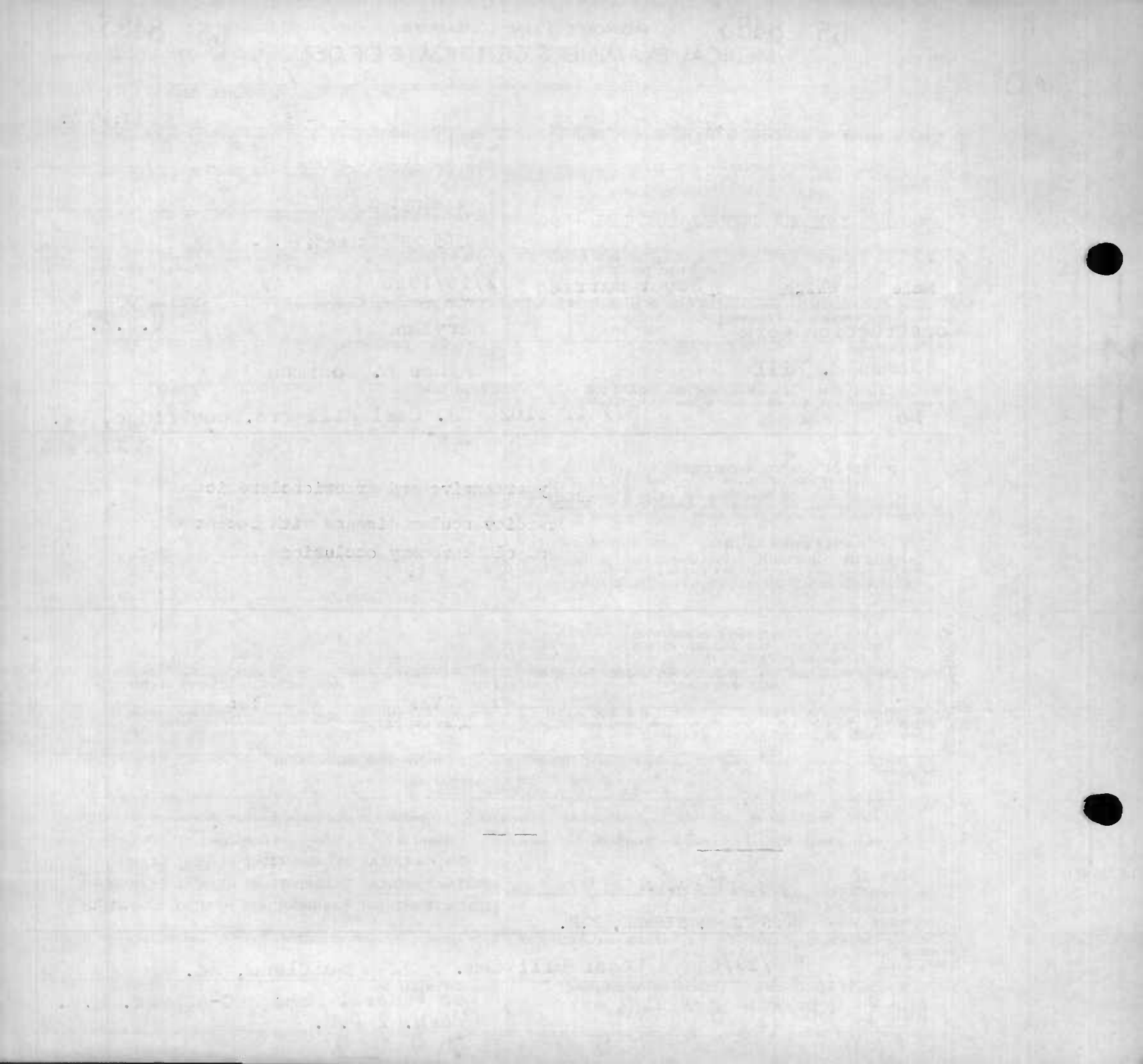
24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Lee Funeral Home 300-4th St. N.E.
Wash. 2 D.C.

ADDRESS



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 8486

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Andrew PEYTON

2. DATE AND HOUR PRONOUNCED DEAD

8/14/65

5.20 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hosp. DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Essex (21)

D. STREET ADDRESS (If rural, give location)

302 Homberg Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

July 13, 1895

9. AGE (In years
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Farm Hand

10B. KIND OF BUSINESS OR INDUSTRY

Farm

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Ephram Peyton

14. MOTHER'S MAIDEN NAME

Mary Breebin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

228 07 8088

17. INFORMANT

Evelyn Rayner

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

R. Breitenacker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
8/15/6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/18/65

23C. NAME of CEMETERY or CREMATORY

Belair Memorial Gardens

23D. LOCATION

(City, town, or county)

Belair, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

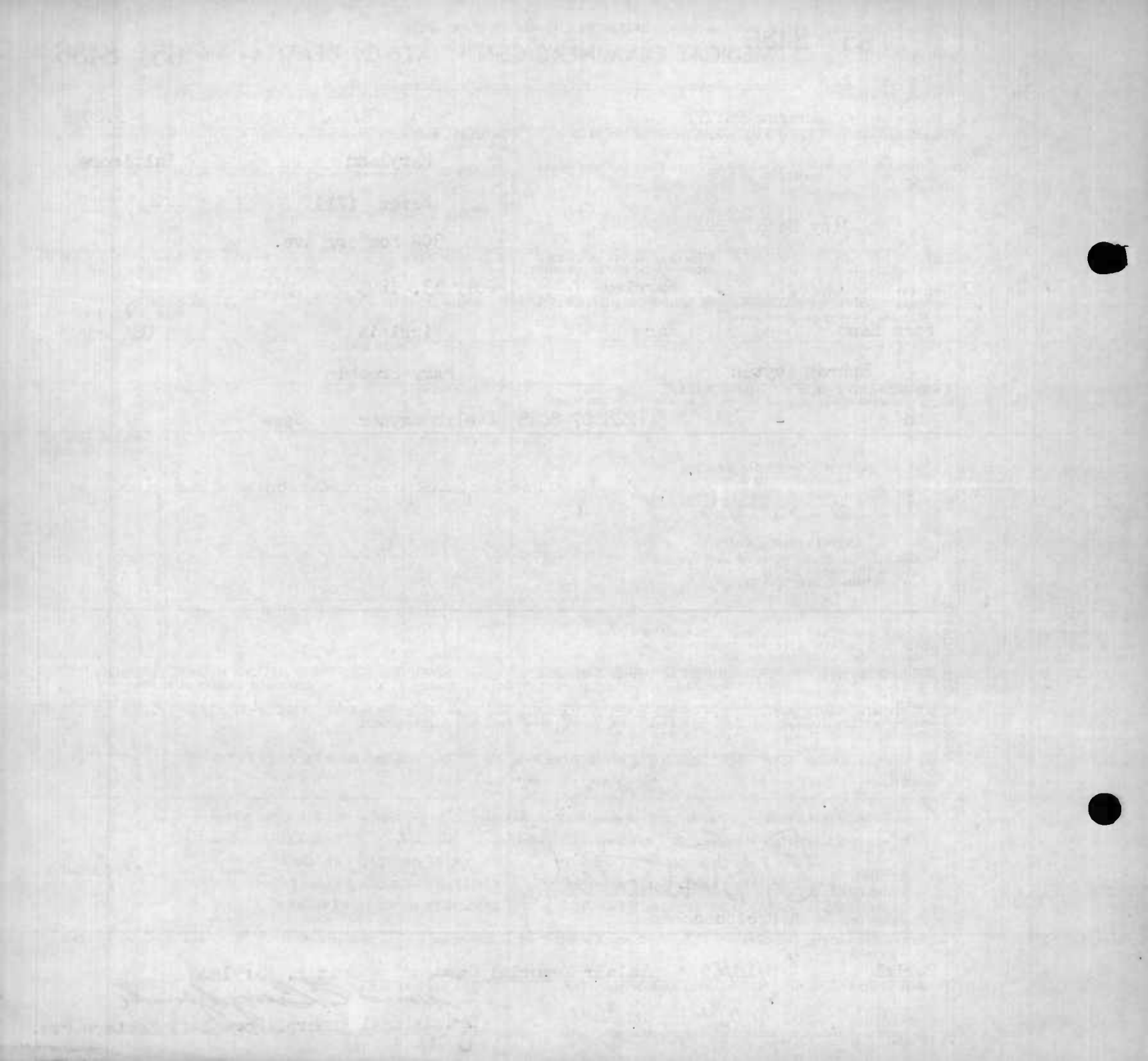
24C. FUNERAL DIRECTOR

ADDRESS

AUG 17 1965

Robert E. Farkner

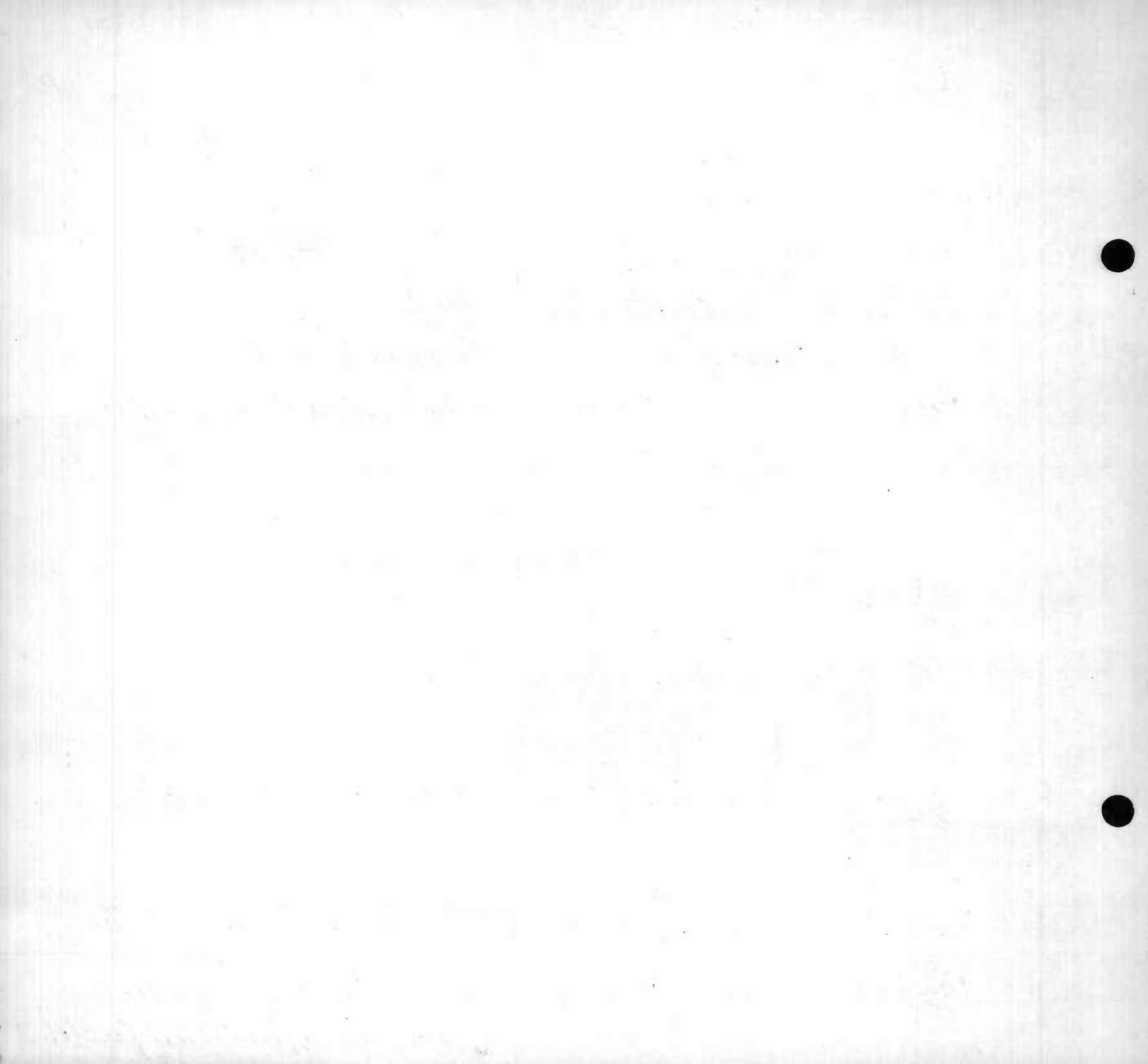
Bruzdzinski Funeral Home 1407 Eastern Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

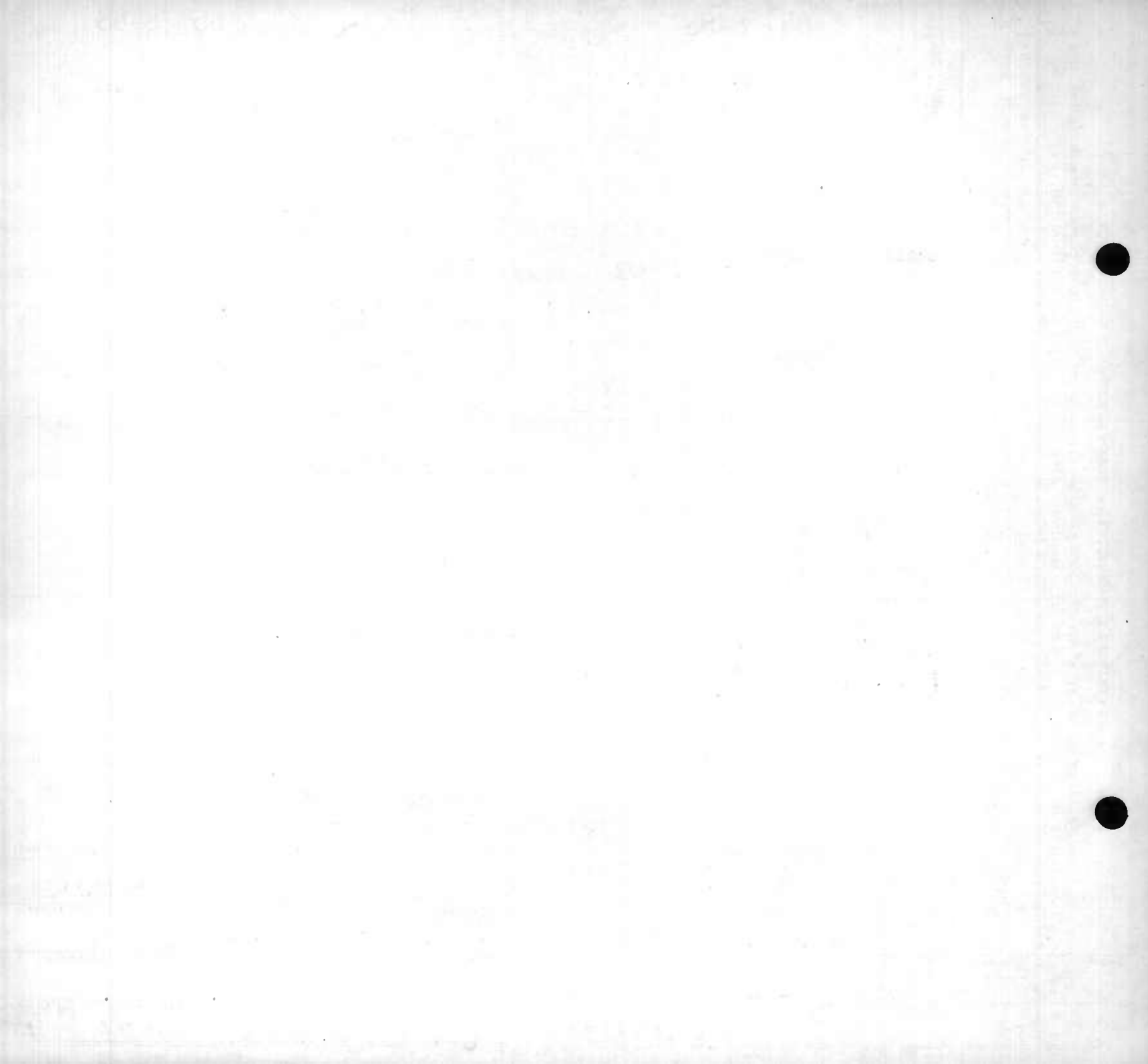
BIRTH NO. 65 8487		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8487	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) WINSTAD, CLARENCE			2. DATE AND HOUR OF DEATH August 15, 1965 8:20 PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-03		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Maryland 730 Ashburton St. Baltimore, Md. 21216			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 16		
			D. STREET ADDRESS (If rural, give location) 1703 Thomas Avenue		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH April 2, 1928	9. AGE (In years lost birthday) 36 37	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Contractor	11. BIRTHPLACE (State or foreign country) M.C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Walter Winstead			14. MOTHER'S MAIDEN NAME Emma Ford		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 238-40-8889	17. INFORMANT Milton Winstead ADDRESS 1702 Flors. ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Toxic Peritonitis			CAUSE OF DEATH Intestinal Obstruction		INTERVAL BETWEEN ONSET AND DEATH one week
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Congenital adhesions, terminal ileum					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 8/10/65; 8/10/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal Obstruction		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 10, 1965 to August 15, 1965 , that (I) (we) last saw the deceased alive on August 15, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 8:20 PM					
23A. SIGNATURE Manuel G. Fontanilla M.D.			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 15, 1965
23C. PHYSICIAN'S NAME (Type) Manuel G. Fontanilla M.D.			23D. ADDRESS Lutheran Hospital, Baltimore, Md. 21216		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/22/65	24C. NAME OF CEMETERY or CREMATORY Family Plot		24D. LOCATION (City, town, or county) (State) Stantonsburg, N.C.	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Wm. J. Whelan, Jr. ADDRESS 1401 Mt. Cullough St. Balto. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

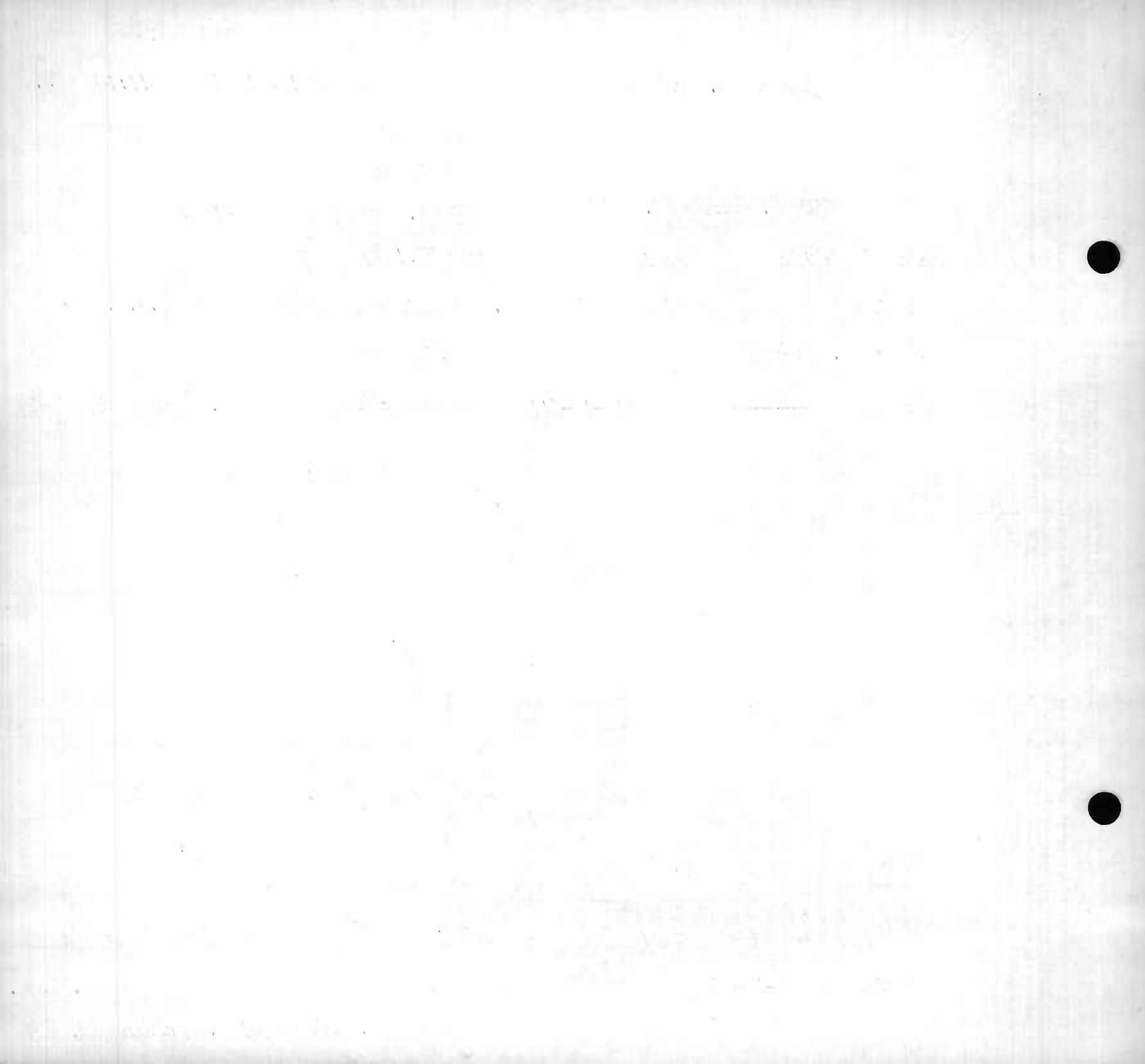
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8488	
BIRTH NO. 65 8488		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GERST, MARY C.		2. DATE AND HOUR OF DEATH August 15, 1965 4:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balt C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 8627 Belair Road - 36			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 4-2-85	9. AGE (In years lost birthday) 80	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Own Home.		11. BIRTHPLACE (State or foreign country) Baltimore, (County) Md.	
13. FATHER'S NAME Henry Kahl		14. MOTHER'S MAIDEN NAME Barbara Noppenberger			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Mrs Margaret Seifried 8627 Belair Road	
18. 15311 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the transverse colon ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Post-operative pneumonitis.		CAUSE OF DEATH (A) Carcinoma of the transverse colon DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION Aug. 9, 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca. of colon		20A. AUTOPSY? (Yes or No) None	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 3, 1965 to August 15, 1965 , that (I) (we) last saw the deceased alive on August 15, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Leonardo A. Tadalon</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED August 15, 1965	
23C. PHYSICIAN'S NAME (Type) Leonardo A. Tadalon				23D. ADDRESS M.D. 1400 N. Caroline Street - 21213	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-18-1965		24C. NAME OF CEMETERY or CREMATORY St. Joseph's Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Co. Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 17 1965			
25B. NAME OF REGISTRAR Robert E. Tadalon		25C. FUNERAL DIRECTOR ADDRESS Funeral Home 7401 Belair Road			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

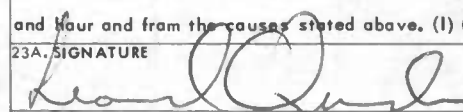
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8489	
BIRTH NO. 65 8489				CERTIFICATE OF DEATH	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Charles A. Eckhardt			August 12, 1965 11:10 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 630 S. Grundy St. #24			A. STATE Maryland B. COUNTY 26-09		
5. SEX Male			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
6. RACE White			D. STREET ADDRESS (If rural, give location) 630 S. Grundy Street 21224		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married			8. DATE OF BIRTH July 27, 1889		
9. AGE (In years last birthday) 76			10. CITIZEN OF WHAT COUNTRY? U.S.A.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		
10B. KIND OF BUSINESS OR INDUSTRY Service Station Oper.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas A. Eckhardt			14. MOTHER'S MAIDEN NAME Elizabeth Kuhn		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-10-5116		
17. INFORMANT Barbara Eckhardt			ADDRESS 630 S. Grundy Street #24		
18. IC3X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of lung			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. None			INTERVAL BETWEEN ONSET AND DEATH ?		
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb. 12 1963 to Aug. 12 1965 that (I) (we) last saw the deceased alive on Aug. 12 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jason H. Gaskel M.D.				23B. DATE SIGNED Aug. 16, 1965	
23C. PHYSICIAN'S NAME (Type) Jason H. Gaskel M.D.				23D. ADDRESS 637 S. Conkling St. Balt. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-16-65		24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cemetery	
24D. LOCATION 7401 German Hill Road Balto, 22, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 17 1965			
25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Charles S. Zeiler			
25D. ADDRESS 901 S. Conkling St. #24					



41-47-38
FR
X-500

FUNERAL DIRECTOR: IMPORTANT

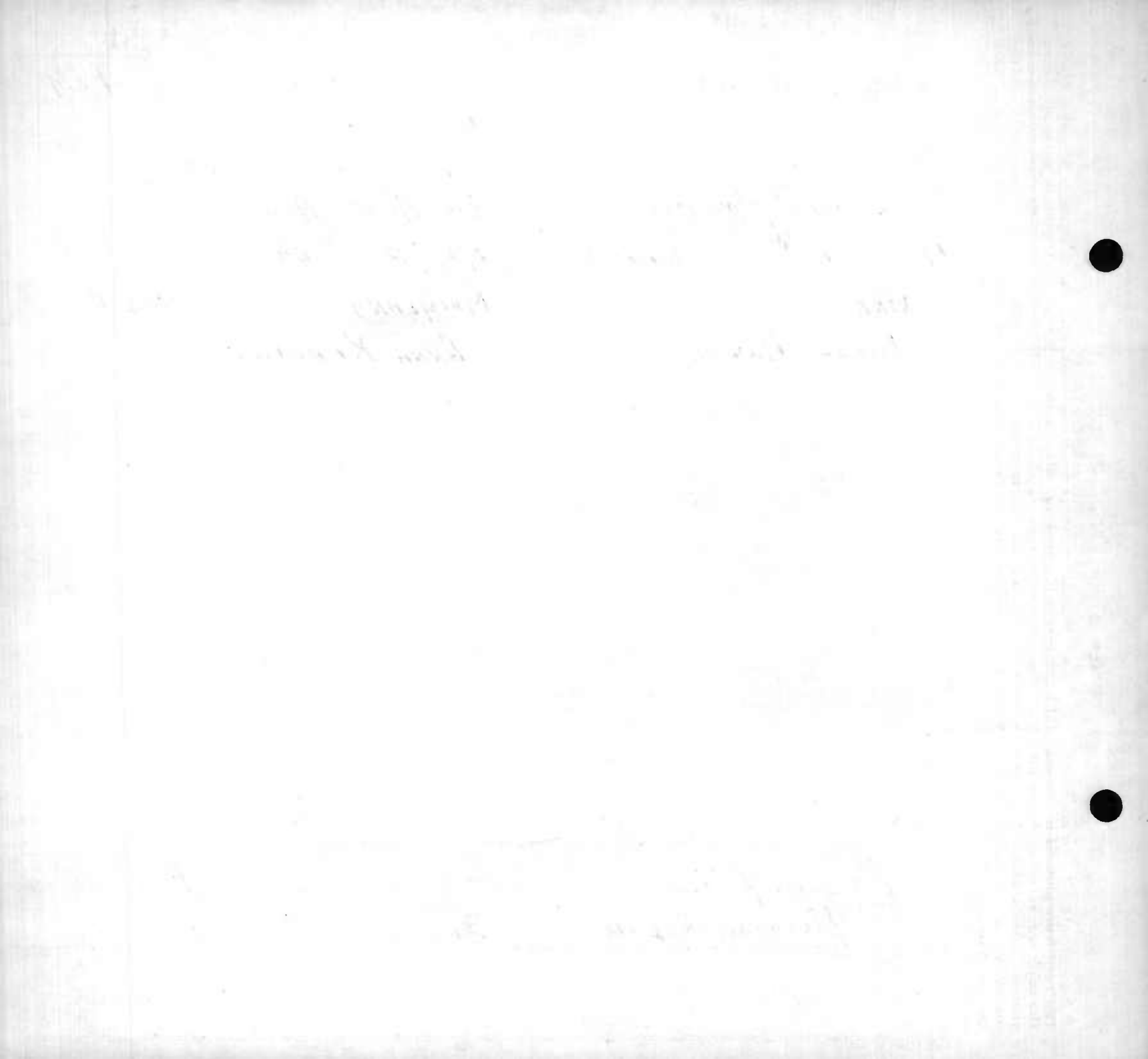
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8490	
BIRTH NO. 65 8490				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) John Kuhn (John C. Kuhn)			2. DATE AND HOUR OF DEATH August 13, 1965 11:25 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-09 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3504 Fleet Street 21224		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9-7-1900	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10B. KIND OF BUSINESS OR INDUSTRY Western Electric Co		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Aloysius Kuhn		
14. MOTHER'S MAIDEN NAME Catherine ?			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 215-03-9116			17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224		
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Cerebral Vascular Accident DUE TO Cerebral Arteriosclerosis (B) Diabetes Mellitus DUE TO 1 Year (C) _____		
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) Yes			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 12, 1965 to August 13, 1965 , that (I) (we) last saw the deceased alive on August 13, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  (M.D.)			23B. DATE SIGNED 8-13-1965		
23C. PHYSICIAN'S NAME (Type) Leonard Quadracci			23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, Md. 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-17-65		24C. NAME of CEMETERY or CREMATORY Sacred Heart Cemetery	
24D. LOCATION (City, town, or county) (State) 7401 German Hill Road Balto. 22, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 17 1965			
25B. NAME OF REGISTRAR Robert E. Foye		25C. FUNERAL DIRECTOR ADDRESS Charles S. Zeiler 901 S. Conkling St. #24			

FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 8491				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8491	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) AGNES, MR. JOSEPH P.				2. DATE AND HOUR OF DEATH 8/14/65 4 PM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS HOSPITAL		(If not in hospital or institution, give street address or location)		A. STATE MD.		B. COUNTY BALTIMORE	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE #28 53-00			
				D. STREET ADDRESS (If rural, give location) 914 KENT AVE			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 8/23/18	9. AGE (In years lost birthday) 47	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH AGNES				14. MOTHER'S MAIDEN NAME ANNA KRAEMER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W. II		16. SOCIAL SECURITY NO. 25-05-2252		17. INFORMANT HARRY LAWRENCE		ADDRESS 914 Kent Ave	
18. 434.1 CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO Progressive Heart Failure			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from August 10 1965 to August 14 1965 , that (X) (we) last saw the deceased alive on August 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Alexander R. Lim				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 14, 1965	
23C. PHYSICIAN'S NAME (Type) Alexander R. Lim				23D. ADDRESS Bon Secours Hosp. Balto. 23			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/18/65		24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1965		25B. NAME OF REGISTRAR Robert E. Talley M.D.		25C. FUNERAL DIRECTOR Amberg Inc		ADDRESS 1378 Sulphur Spring Rd.	



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 8492

M.E. CASE NO.

1. NAME OF DECEASED (Also known as Vern)
(Type or Print) Vernon E. KRAFT2. DATE AND HOUR PRONOUNCED DEAD
8/14/65

12.45 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md. 21218 B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
BaltimoreD. STREET ADDRESS (If rural, give location)
709 E. 37th St.,**CERTIFICATE AMENDED**

J. Hopkins Hosp.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

9/8/17 9/7/17

9. AGE (In years
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.
Months; Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Blending Dept.

10B. KIND OF BUSINESS OR INDUSTRY

Paul Jones Dist.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Michael Kraft

14. MOTHER'S MAIDEN NAME

Ella Ganz

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

W.W. 2

16. SOCIAL
SECURITY NO.
218-07-101917. INFORMANT 2702 Erdman Ave. ADDRESS
Shirley Cogle, step-dght.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)

Multiple traumatic injuries

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.) street21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Intersection Moravia Rd. and Sinclair lane

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
8 13 65 11:50

21E. INJURY OCCURRED

WHILE AT
P.m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

auto-auto collision, driver

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S NAME (Type) Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/14/65

23A. BURIAL CREMATION,
REMOVAL (Specify)
Burial

23B. DATE

8/17/65

23C. NAME OF CEMETERY or CREMATORY

Balto. Nat. Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

AUG 17 1965

24B. NAME OF REGISTRAR

Robert E. Farkas, M.D.

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.
3331 Brehms Lane

ADDRESS

vs 153 signed by licensed funeral director. C. Bowens

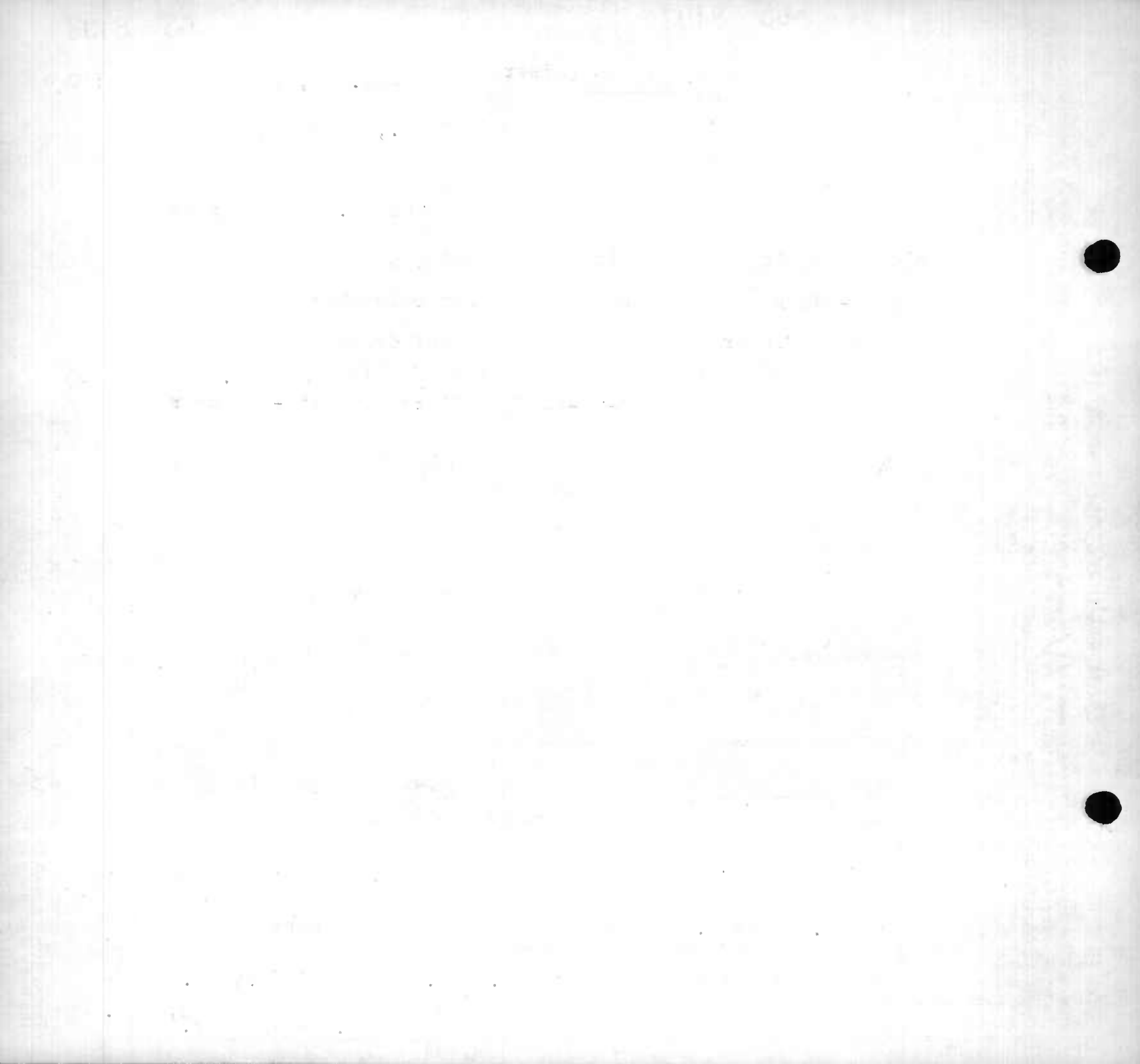
CITIZENRY LEARNED

VALLEY FORCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8493	
BIRTH NO. 65 8493		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOSEPH F. FISHER (Fiser)		Aug. 15, 1965 1:30 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
Gould Nursing Home				Md., 21205 7-04	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
				Baltimore	
				D. STREET ADDRESS (If rural, give location)	
				2038 E. Eager Street	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days Hours Min.
male	white	single	12/10/84	80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
retired-clerk		unknown		Czechoslovakia	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Frank Fisher			Catherine?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		219-05-7645		4315 Penn Ave., Zone 36 Mildred Vrzalik-2nd cousin	
18. 416X + 163X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES		(A) Rheumatic Heart disease DUE TO			?
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Ca - Lung DUE TO			5 years
		(C) Emphysema			5 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 19 60 to Aug 15 19 65 , that (I) (we) last saw the deceased alive on aug 14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. Louis F. Klimes				8/16/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Louis F. Klimes		4814 Bowleys Lane			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8/18/65		Bohemian Nat. Cem.	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 17 1965		Robert E. Farley		Schimunek Funeral Home, Inc.	
				2601 E. Madison St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8494		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 8494	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) JOHN McFarlane ROCHE		2. DATE AND HOUR OF DEATH 8/14/65 10 ⁵⁵ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Harford			
FULL NAME OF DECEASED (If not in hospital or institution, give street address or location) 8/23/65 UNION MEMORIAL HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BEL AIR 65-32			
				D. STREET ADDRESS (If rural, give location) 7 BROOKS Rd.			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 12/4/1904	9. AGE (In years lost birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SAFETY ENGINEER ARSENAL		10B. KIND OF BUSINESS OR INDUSTRY EDGEMOOD		11. BIRTHPLACE (State or foreign country) USA OLEAN, N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MICHAEL S. ROCHE				14. MOTHER'S MAIDEN NAME HARRIET B MC FARLAND			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 091-09-2328		17. INFORMANT (Name and address) (Wife) (838-4738) CONSTANCE M. Roche 7 Brooks Rd. Bel Air, Md. 21014			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 715X I Septicemia				CAUSE OF DEATH Infected granuloblastic ulcers - left leg		INTERVAL BETWEEN ONSET AND DEATH 5d	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/13 1965 to 8/14 1965, that (I) last saw the deceased alive on 8/14 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.							
23A. SIGNATURE William R. Linton, Jr.				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/14/65	
23C. PHYSICIAN'S NAME (Type) DR. WILLIAM R. LINTON, JR.				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE August 16, 1965		24C. NAME OF CEMETERY or CREMATORY Bel Air Memorial Gardens		24D. LOCATION (City, town, or county) (State) Bel Air, Harford Co, Maryland 21014	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1965		25B. NAME OF REGISTRAR Robert E. Foster		25C. FUNERAL DIRECTOR Joseph William Foster ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014			

Vs 153 signed by funeral director Joseph Foster. C. Bowens Sr. Clk. Typ.

FUNERAL DIRECTOR: IMPORTANT

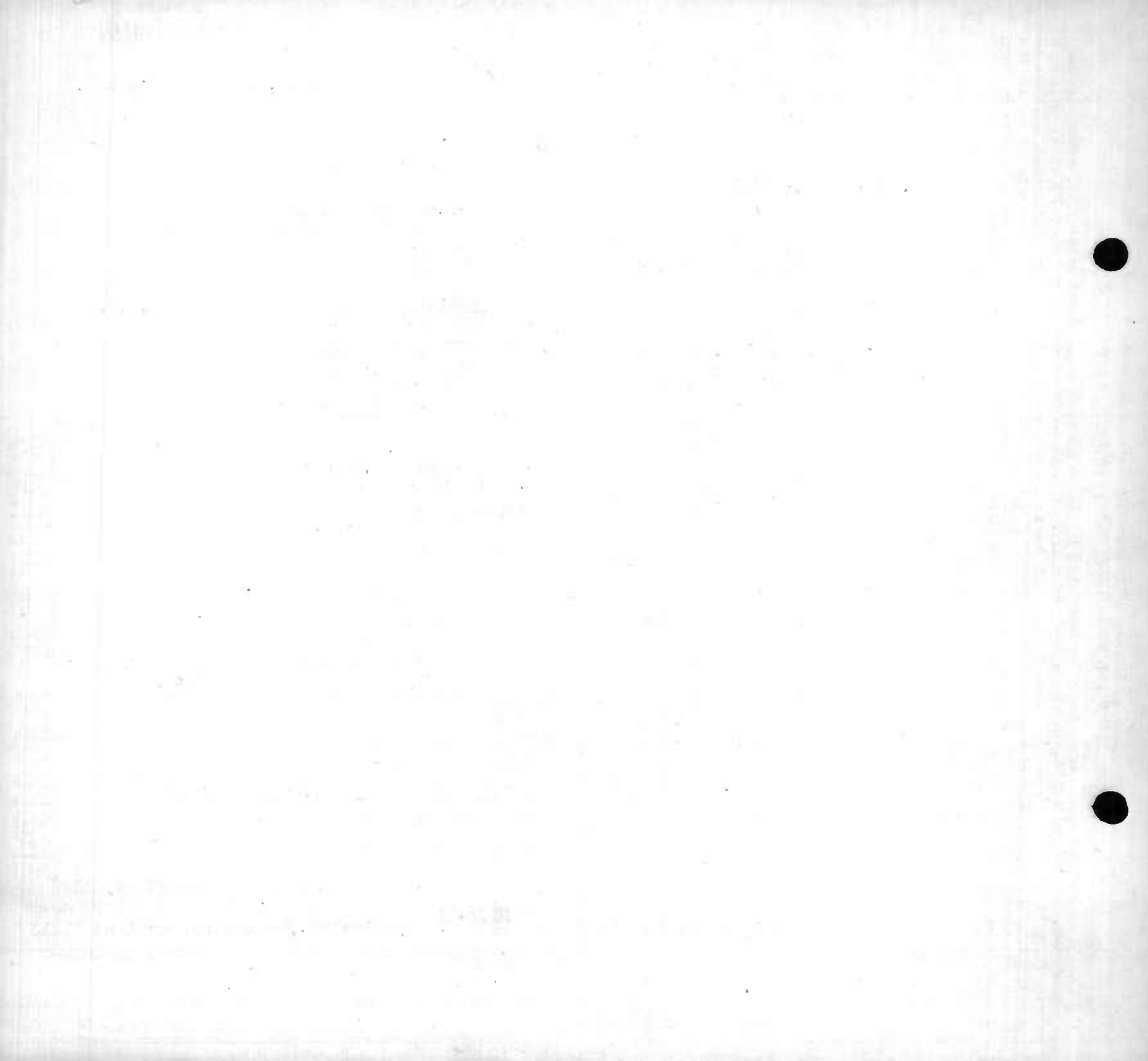
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 8495	
BIRTH NO. 65 8495		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Harry Dawson Mitchell, Jr.		August 13, 1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
5320 Bosworth Avenue		Maryland Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		5320 Bosworth Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	White	Married	May 29, 1895	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
Salesman-manger				U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Harry D. Mitchell		Nellie Horn			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes WW 1		212-03-0793		Elizabeth Mitchell 5320 Bosworth Avenue	
18. 527.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) COR PULMONALE DUE TO		10 YRS.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slofing the UNDERLYING CONDITION lost.		(B) CHRONIC EMPHYSEMA DUE TO		20 YRS.	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JULY 25, 1965 to AUG. 13, 1965, that (I) (we) last saw the deceased alive on AUG. 3, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
MARVIN GOLDSTEIN				8/16/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
MARVIN GOLDSTEIN		5334 LIBERTY HEIGHTS, BALTO, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/16/65		Woodlawn Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 17 1965		Robert E. Faden		Ellsworth Armacost 4600 Liberty Heights	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 8496				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8496	
M.E. CASE NO. 65 8496				1. NAME OF DECEASED (Type or Print) HOBBS, DORA			
2. DATE AND HOUR OF DEATH August 12, 1965 11:20 P. M.				3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore 18			
5. SEX Female				6. RACE Negro		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	
8. DATE OF BIRTH 8/13/91				9. AGE (In years last birthday) 74		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Newsome				14. MOTHER'S MAIDEN NAME Julia Sykes			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mommie Hobbs 2028 Robb St	
18. 570.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) Fresh spotty hemorrhagic infarctions of small and large intestines (B) DUE TO (C)			
INTERVAL BETWEEN ONSET AND DEATH				ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
MEDICAL CERTIFICATION				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/12 19 65 to 8/12/ 19 65, that (I) (we) last saw the deceased alive on 8/12 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Govinda Rao				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 13, 1965	
23C. PHYSICIAN'S NAME (Type) Govinda Rao				23D. ADDRESS 1400 N. Caroline St., Baltimore, Maryland 21213			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/17/65		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem		24D. LOCATION (City, town, or county) (State) Balt. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1965		25B. NAME OF REGISTRAR Robert E. Fairley		25C. FUNERAL DIRECTOR Wm C. March		ADDRESS 928 E North Ave	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 8497

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Albert DAVIS

2. DATE AND HOUR PRONOUNCED DEAD

8/15/65

5.45 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2109 Callow Ave

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

6/17/17

9. AGE (In years
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Mechanic Helper

10B. KIND OF BUSINESS OR INDUSTRY

Auto

11. BIRTHPLACE (State or foreign country)

Marion S Carolina

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Arthur Davis

14. MOTHER'S MAIDEN NAME

Minnie

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW 2

16. SOCIAL
SECURITY NO.
247-26-4870

17. INFORMANT

ADDRESS

Mr Raymond Lee Davis 2111 Callow Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Massive internal hemorrhage
DUE TO

Stabwounds of back

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2101 Bolton str.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

8

15

65

5.30

21E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

stabbed during altercation

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

R. Breitenecker

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/15/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

8/20/65

23C. NAME of CEMETERY or CREMATORY

Dillon

23D. LOCATION (City, town, or county) (State)

South Carolina

24A. DATE REC'D BY HEALTH DEPT.

AUG 17 1965

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

ADDRESS

Adolphus Halstead 1206 W North Ave

VALLEY FORDGE

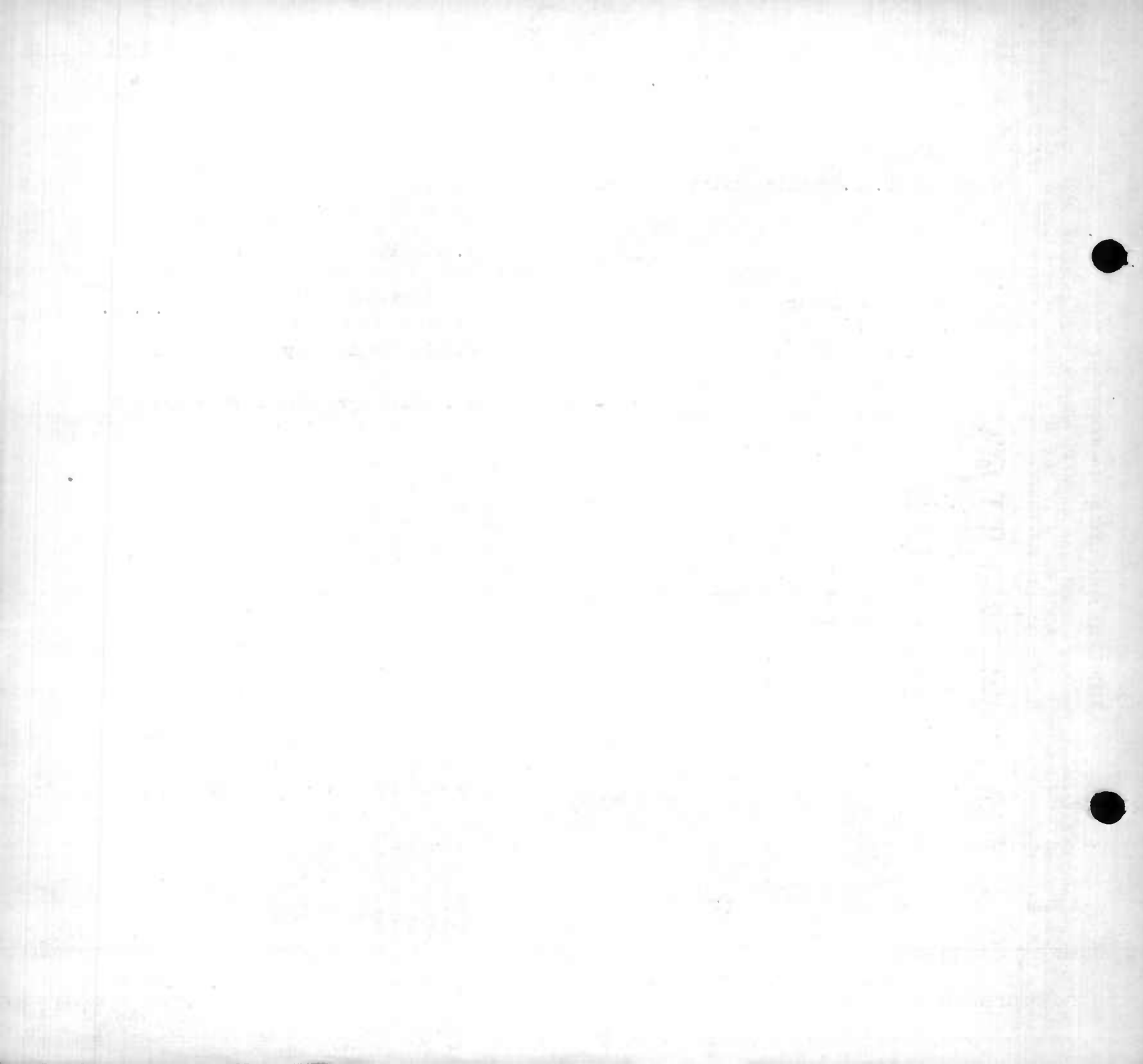
PAHICOMMUNITY

Address: [illegible]
Phone: [illegible]
Date: [illegible]

FUNERAL DIRECTOR: IMPORTANT

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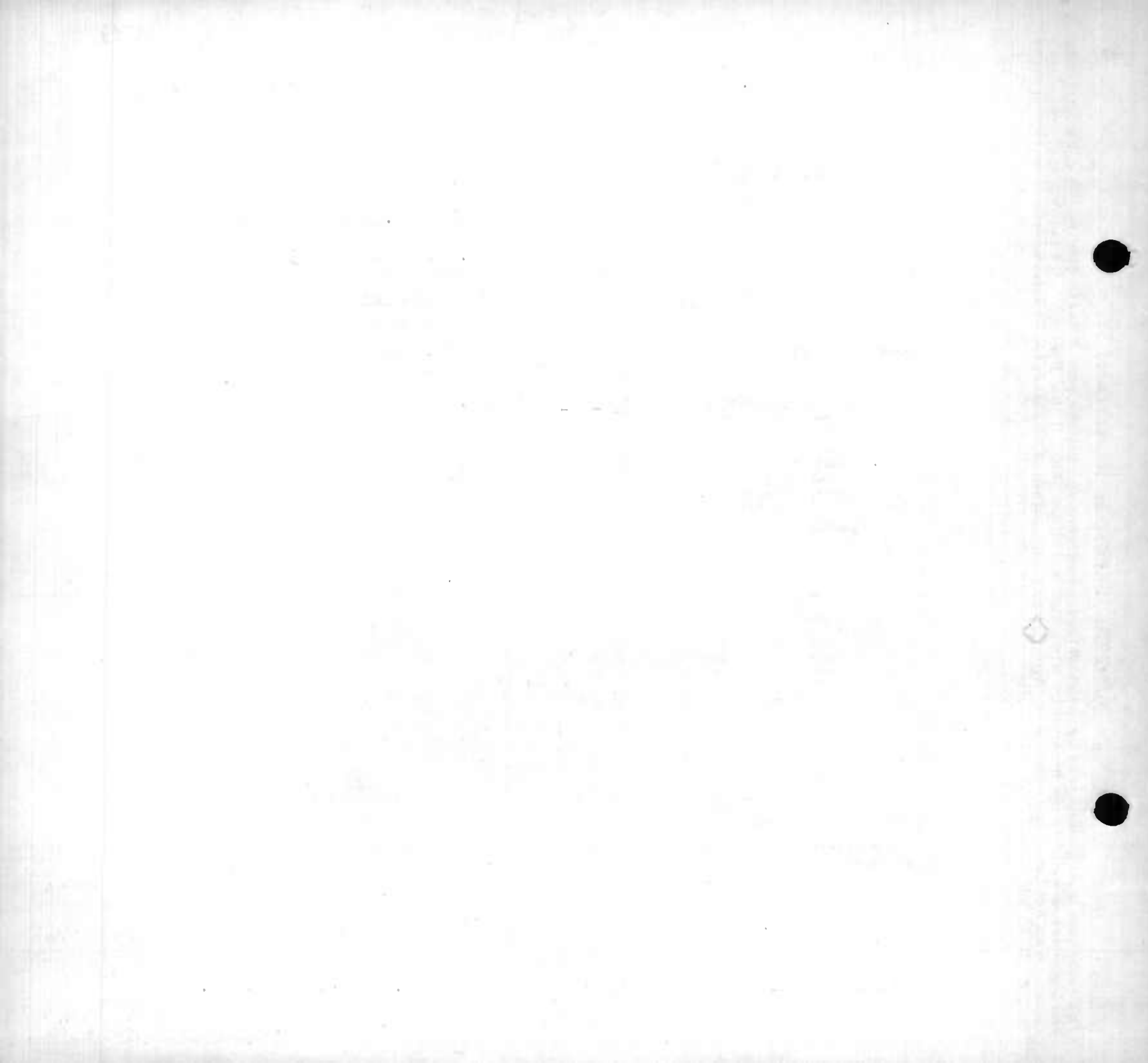
BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
M.E. CASE NO. 65 8498				CERTIFICATE OF DEATH		65 8498	
1. NAME OF DECEASED (Type or Print) EUGENE W. KEY				2. DATE AND HOUR OF DEATH 14 AUGUST 1965 11:25 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE DEL		B. COUNTY K-07	
57 U. S. Public Health Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township) REHOBOTH BEACH			
				D. STREET ADDRESS (If rural, give location) 212 LAUREL ST			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH Oct. 21, 1908	9. AGE (In years last birthday) 56	If Under 1 Yr. Months	If Under 24 Hrs. Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine Engineer			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Utica, New York		12. CITIZEN OF WHAT COUNTRY? U.S. A.
13. FATHER'S NAME Clifford Key			14. MOTHER'S MAIDEN NAME Jessie Bentley Key Reifenkugel				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 076-07-3279		17. INFORMANT Mrs. Helen Byrd Key same address		
18. 1046.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) CONGESTIVE HEART FAILURE DUE TO		DAYS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) MALABSORPTION SYNDROME DUE TO		MONTHS	
				(C) ANEMIASIS		MONTHS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/19 1965 to 8/14 1965, that (I) (we) last saw the deceased alive on 8/14 1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Thomas Lau				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 14 AUGUST 65	
23C. PHYSICIAN'S NAME (Type) THOMAS LAU				23D. ADDRESS M.D. USPHS HOSPITAL BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/17/1965		24C. NAME OF CEMETERY or CREMATORY Epworth Methodist Cemetery		24D. LOCATION (City, town, or county) Rehoboth Beach, Delaware (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1965		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Wm. J. Johnson & Sons		ADDRESS 21217 North Pa. Ave.	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 65 0450					CERTIFICATE OF DEATH					Registered No. 65 8499									
1. NAME OF DECEASED (Type or Print) Edgar O. Warnken					2. DATE AND HOUR OF DEATH August 14, 1965 8:15 p. m.														
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-13 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2625 W. Cold Spring Lane 15														
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH Dec. 2, 1911		9. AGE (In years lost birthday) 53		10. Under 1 Yr. Months Days		11. If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant					10B. KIND OF BUSINESS OR INDUSTRY Gas Station					11. BIRTHPLACE (State or foreign country) Maryland									
12. CITIZEN OF WHAT COUNTRY?					13. FATHER'S NAME Ferd Warnken					14. MOTHER'S MAIDEN NAME Eleanor Byron									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II					16. SOCIAL SECURITY NO. 215-09-2705					17. INFORMANT ADDRESS 2625 W. Cold Spring Lane Mrs. Osma Warnken Baltimore, Maryland 15									
18. 42011 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										(A) Coronary occlusion DUE TO					INTERVAL BETWEEN ONSET AND DEATH 1 hour				
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)									
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)									
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
21F. HOW DID INJURY OCCUR?					22. I certify that (I) (this hospital) attended the deceased from Aug. 13, 1965 to Aug. 14, 1965, that (I) (we) last saw the deceased alive on Aug. 13, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE Abraham B. Hurwitz					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED Aug. 16, 1965									
23C. PHYSICIAN'S NAME (Type) ABRAHAM B. HURWITZ					23D. ADDRESS 7501 LIBERTY ROAD, BALTIMORE, MD.														
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 8/18/1965					24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.									
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					25A. DATE REC'D BY HEALTH DEPT. AUG 17 1965					25B. NAME OF REGISTRAR Robert E. Taylor									
25C. FUNERAL DIRECTOR Wm. J. Dickerson & Sons					25D. ADDRESS Baltimore, Md. 17														



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BIRTH NO. 65 8500		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 8500	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Carrie T. Miller		8-15-1965		8: 45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		Maryland			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
Female		White		Widow	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
George Miller		Amelia Thames Hammack		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		218120947		Records: BCH-4940 Eastern Avenue 21224	
18. 42211 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		Bronchopneumonia		2 days	
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Left Middle Cerebral Artery		4 days	
		(B) DUE TO			
		Thrombosis			
		(C) DUE TO			
		Arteriosclerotic Cardio		Many years	
		Vascular Disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-12-1965 to 8-15-1965, that (I) (we) last saw the deceased alive on 8-15-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Sidney D. Kreider				8-15-1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Sidney D. Kreider		M.D. 4940 Eastern Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
burial		8-19-65		Baltimore Nat'l Cemetery	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 17 1965		Robert E. Fugate		Leonard J. Ruck Inc Baltimore, Md.	

